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ABSTRACT

This document opens with a statement from President Nixon's Health Message to Congress on February 15, 1971, acknowledgements, a letter of transmittal, the charge to the committee and activities of the committee. The report itself consists of information on the changing needs for health education, purposes and challenges of health education, and two sections of findings and recommendations--those concerned with national activities in support of health education, and those regarding a proposed National Center for Health Education. Supplementary statements of support and dissent, listings of the states represented at regional hearings, planning councils for regional hearings, neighborhood health center directors who attended special meetings on December 6&7, 1971, governmental agencies represented at subcommittee discussions of their possible role in health education, organizations which responded to questionnaires, governmental agencies which responded to the chairman's request for information, and persons who gave testimony at regional hearings are appended. (KP)

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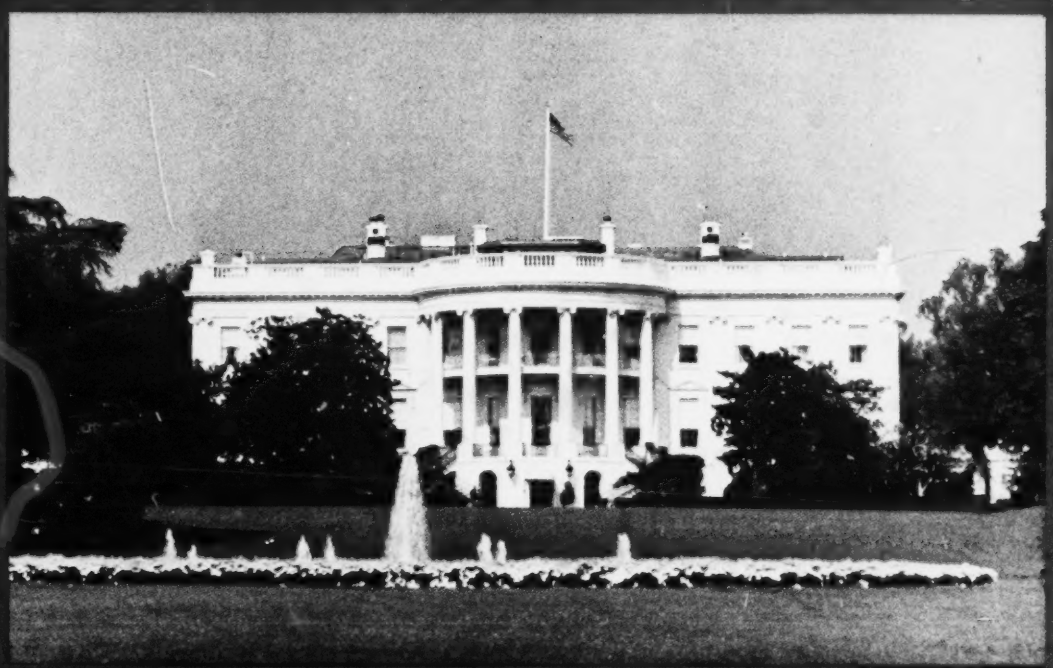

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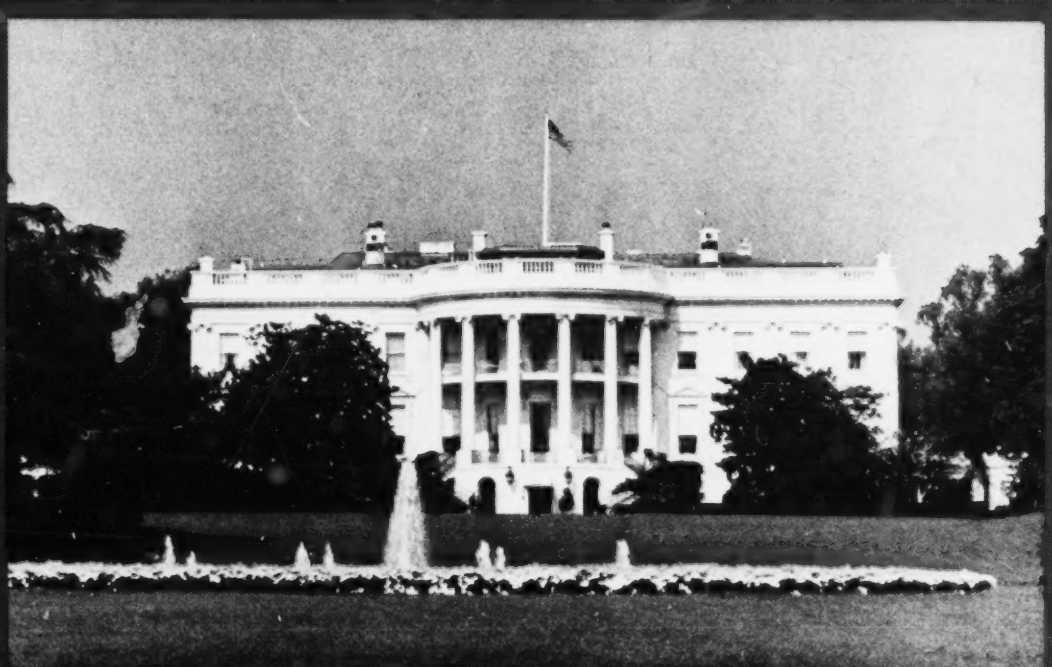

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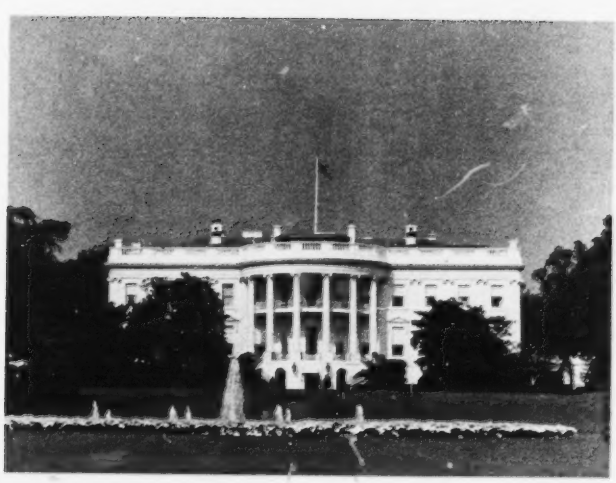

The Report
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On Health Education

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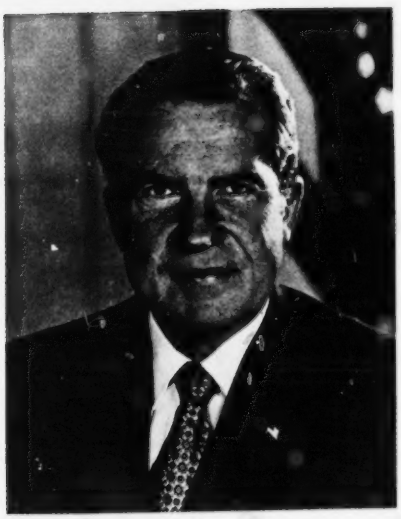
"...A Comprehensive Health Education Program."



In the final analysis, each individual bears the major responsibility for his own health. Unfortunately, too many of us fail to meet that responsibility. Too many Americans eat too much, drink too much, work too hard and exercise too little. Too many are careless drivers.

These are personal questions, to be sure; but they are also public questions. For the whole society has a stake in the health of the individual. Ultimately, everyone shares in the cost of his illnesses or accidents. Through tax payments and through insurance premiums, the careful subsidize the careless; the nonsmokers subsidize those who smoke; the physically fit subsidize the rundown and the overweight; the knowledgeable subsidize the ignorant and the vulnerable.

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Health message to the Congress
February 15, 1971

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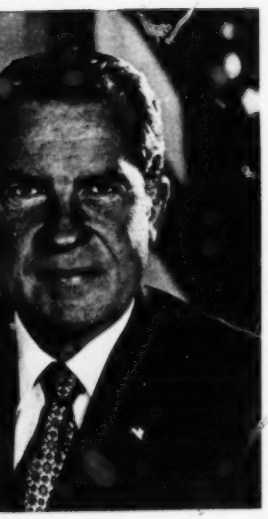

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It is in the interest of our entire country, therefore, to educate and encourage each of our citizens to develop sensible health practices. Yet we have given remarkably little attention to the health education of our people.

Most of our current efforts in this area are fragmented and haphazard—a public service advertisement one week, a newspaper article another, a short lecture now and then from the doctor.

There is no national instrument, no central force to stimulate and coordinate a comprehensive health education program.

Richard Nixon

Health message to the Congress
February 15, 1971

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RICHARD P. McGRAIL has been Deputy Executive Vice President of the American Cancer Society, Inc., since 1961 and has served the Society in various capacities since 1946. A member of the New York County Lawyers Association and the Nassau Bar Association, Mr. McGrail is Immediate Past President of the National Health Council, and now serves on its Board.

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ELLIOT LEE RICHARDSON served as United States Secretary of Health, Education, and Welfare from June 6, 1970, until his confirmation as Secretary of Defense in 1973. Prior to that he was Under Secretary of State. From 1964 to 1966, as Lieutenant Governor of Massachusetts, he coordinated the state's health, education and welfare programs and headed the task force which produced the Community Mental Health Act and developed a multi-service agency program. He was elected A of the Commonwealth in 1966. The Secretary is a of the Board of Overseers of Harvard College ber of the Council on Foreign Relations, a Fellow Academy of Arts and Sciences, and a Fellow of th Foundation. He was appointed by President Nix of Governors of the American National Red Cros

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Dedication

TO JOSEPH C. WILSON

When I was asked to undertake the chairmanship of the Committee following the untimely death of Joseph C. Wilson, I was aware that while this truly remarkable and dedicated man could be substituted for, he could never be replaced.

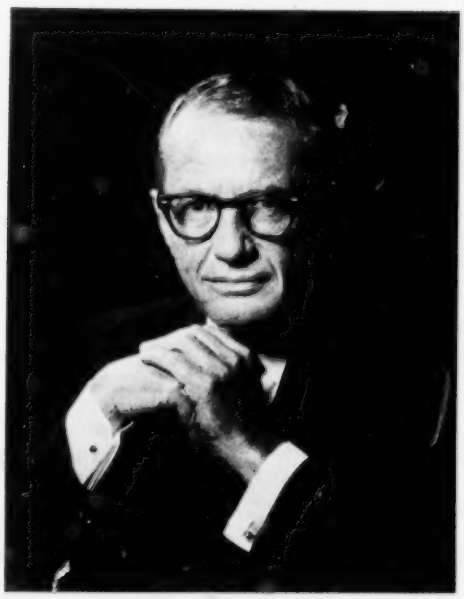
I can only hope that in preparing this report, we have been as dispassionate in our findings and as compassionate in our conclusions as he would have wanted.

R. Heath Larry
Chairman

In Memoriam

To set high goals
To have almost unattainable aspirations
To imbue people with the belief that
they can be achieved
These are as important as the balance sheet
Perhaps more so

Joseph C. Wilson
1909-1971



Acknowledgements

The Committee expresses its sincere appreciation to the nearly 2,000 persons who played some instrumental role in its efforts.

We are grateful to the many individuals, low-income groups, professionals and representatives of public and private organizations, institutions, agencies and others who took time to testify at our public hearings or to communicate with us individually.

We also thank the companies and organizations which contributed valuable staff time to the study; the life and health insurance associations; the Blue Cross Association; the National Association of Blue Shield Plans; the Con
Health Services and Mental Health Admini
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Council for its part in collecting and disbu
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House staff and the Department of HEW v
aspects of our inquiry; and the Institute of
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Letter Of Transmittal

Dear Mr. President:

Your Committee on Health Education has completed the assignment you gave it September 14, 1971. On behalf of the Committee, I thank you for making it possible for those of us on the Committee to discover for ourselves—and hopefully, through this report, for the benefit of the nation—how deplorably this country is neglecting a vast opportunity to help people help themselves to have better health.

The recent and continuing debate over national health insurance has uncovered a great deal of concern about the delivery and financing of health care. That concern is felt by the public as well as by government and private institutions both inside and outside of the health field.

However, after more than a year of intensive study and research, we are convinced that results of any changes or improvements in the delivery and financing of health care will be virtually nullified unless there is, at the same time, an improvement in health education—which means not just supplying information about health to people, but motivating them to accept the information and put it to work in their daily lives.

Unfortunately, the important, and often crucial role the individual can play in maintaining his own health has rarely been clearly explained or adequately dramatized.

Our findings regarding the ignorance or apathy—or both—of American institutions and organizations, indeed, the public at large, toward health education are chronicled in the body of our report. A few of the major findings can, however, be summarized in a few paragraphs:

—While the need and demand for health care services have been rising, health education has been neglected. Many, perhaps most major causes of sickness and death can be affected—and some prevented—by individual behavior, yet the whole field of health education is fragmented, uneven in effectiveness and lacks any base of operations. No agency inside or outside of government is either responsible for, or even assists in setting goals, maintaining criteria of performance or measuring results.

—School health education in most primary and secondary schools is either not provided at all or is tacked onto other subject matter such as physical education or biology, assigned to teachers whose main interests and qualifications lie elsewhere.

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of effective school health programs. Some state
what can be taught have not been changed since

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—In many states, legislation actually impedes development of effective school health programs. Some state laws regarding what can be taught have not been changed since the late 1800s.

—The U.S. Office of Education (Department of HEW), in a report prepared for the Committee, could not cite a single program of research or evaluation it is supporting in the area of school health education.

--What is taught to children is not made meaningful enough to stay with them. Nutrition studies show that teenagers—especially girls—often damage their health through poor eating habits. Other studies show that youngsters who once urged their parents not to smoke have themselves become cigarette smokers as teenagers.

—For all age groups, health education has generally been stereotyped. Its programs have not been—but must be—structured to reflect the cultural mores of each population group being approached. There is vital need for innovation and experimentation with new kinds of educational programs.

—The vast majority of people—88 per cent in one population survey—look to their physicians or TV commercials for information about health. Yet evidence presented to the Committee indicates that physicians are often too busy to do an effective job, and too many TV messages are primarily concerned with product promotion rather than with true consumer health education. Providers of care, such as hospitals, do little to overcome deficiencies. Neither voluntary health organizations nor insurance carriers (private or non-profit) have exploited fully their opportunities.

—Of $75-billion spent last year for medical, hospital and health care—more than $200-million a day—about 92 per cent is spent for treatment after illness occurs. Of the remaining amount, more than half is spent for biomedical research. Prevention of illness and health education share the balance, with health education receiving the short end.

—Of $18.2-billion allocated in 1973 for medical and health activities of the Department of HEW, only $30-million is for specific programs in health education; $14-million more for general programs. That amounts to less than one-fourth of one per cent. Of $7.3-billion allocated for health purposes to all other

federal agencies, even a smaller fraction is spent on health education.

—On the state level, health departments spend less than half of one per cent of their budgets for health education.

—A considerable number of employers have become concerned with acute, dramatic, work-related problems such as alcohol and drug abuse. But business, industry and labor are not significantly involved in over-all programs that could contribute to sound off-job safety and health practices that could also benefit on-job attendance and productivity.

As you will see in the report, it is evident from our inquiry that the needs, problems and opportunities in health education are so large, so urgent and so complex that progress will depend upon a major long-term commitment to it by the nation's leaders.

It is equally evident that the responsibility, the challenge and the burden of providing for the widespread need, solving the problems and meeting the opportunities must be shared by all concerned and capable parties in both the public and private sectors of society.

To bring public and private efforts together, and to provide a focal point for the nation's multiple health education activities, the Committee has recommended establishment of a "National Center for Health Education" to be authorized by the Congress and sustained by both public and private support.

In addition, we have developed a list of additional recommendations—for governmental and private activities—to develop, strengthen, unify and evaluate health education in this nation. Details will be found in the four sections of the report:

1. "Changing Needs for Health Education," describing changes in health problems and the methods of health care in the last few decades and pointing out their implications for health education.

2. "Purposes and Challenges of Health Education," showing what health education is and what it can hope to do.

3. "National Activities in Support of Health Education," telling how virtually every element of soci
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4. "National Center for Health Educ
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telling how virtually every element of society can play a role in making health education a reality.

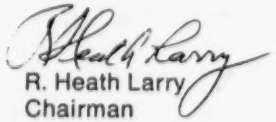
4. "National Center for Health Education," proposing the establishment of a central organization to stimulate and coordinate effective programs in health education.

It is important to note that while our subject is health education, we have tried to stress throughout the report that substantial improvement in the health of Americans depends on many factors outside of the medical structure as well as on those inside it. Certainly there is a need to work with the whole health care delivery system to assure that every person has access to it and that every person who enters the system benefits from it to the highest extent possible. But at the same time we must recognize that good health also is affected by broader opportunities for good jobs, a reduction in joblessness and its consequent poverty, more adequate housing, a higher level of education and an upgrading of the physical environment.

I particularly appreciate the degree to which consensus became possible—notwithstanding that each individual brought to the Committee's deliberation a separate and distinct background of experience—which led almost to as many separate and distinct views concerning what should become the major emphasis of the report. As is inevitable, some viewpoints are expressed with less emphasis than some members would feel appropriate. Hence, this document may share some of the shortcomings which so often must characterize the product of committees. Nevertheless, we are hopeful that what has emerged—for the most part as our consensus—will contribute to the ongoing emphasis upon health education—upon the importance of which we are totally unanimous.

As a final thought, on my behalf, I would like to express my special appreciation to the agencies, organizations and institutions whose executives, staff or faculty were given the time and support to serve on the Committee. The dedication of each Committee member, and the time each gave to the work of the Committee, are the ultimate assets that made this report possible.

Sincerely yours,



R. Heath Larry
Chairman

Charge to The Committee

1. TO DESCRIBE the "state of the art" in health education of the public in the United States today by means of broad-sweep inquiries that would—
   (a) *Identify* the principal areas of activity; the institutions, agencies, programs involved; the characteristics of programs and on-going activities; the interrelationships and interdependencies of the activities; and
   (b) *Assess* effectiveness and levels of participation in terms of the principal component function of health education of the public, with particular reference to behavioral change and community action.
2. TO DEFINE the nation's need for health education programs, and their basic characteristics, in terms of major groupings of health consumers, including the well and the non-well; mothers, children, and youths; the working population; residents of the inner cities and rural areas; the aged and the disabled.
3. TO ESTABLISH goals, priorities, and immediate and long-range objectives of a comprehensive, nation-wide effort to raise the level of "health consumer citizenship."
4. TO PROPOSE the most appropriate scope, function, structure, organization, and financing of such an effort, possibly in the form of a "National Health Education Foundation," giving particular attention to constructive activities now performed by private, professional, and governmental groups.
5. TO DEVELOP a plan for the implementation of its recommendations.

The Scope of Health Education of the Public

The term "health education of the public"—*consumer health education*—embraces those processes of communication and education which help each individual to learn how to achieve and maintain a reasonable level of health appropriate to his particular needs and interests, and to be motivated to follow personal and community health practices whi his state of health and well-being—a positive co beyond the mere absence of disease or infirm

The Health Consumer Education which th asked to facilitate for the nation is a proce dynamically involve the entire citizenry, and sh toward individual and community action. The on the whole person in his natural commun individual's needs and responsibilities . . .

First, to *know* himself, and to shape his life s his personal options for living fully.

Second, to *utilize* health resources and ser onmental support, with optimal efficien

Third, to *participate* constructively in comm environmental planning, in priority-sett sion-making.

Consequently, the deliberation of this co encompass the full range of elements which go concept of *health consumer citizenship.* The quiries would probe into such factors as disease accident prevention . . . the health care in h maintenance organizations, and other health fa tems . . . public health, and environmental hea ecological consideration . . . exercise, diet an rehabilitation . . . mental health . . . educationa educational aspects of health services in scho facilities, in industries, and on farms—and their in with other community health activities . . . rec and career development of health personnel, bo for health consumer education services and th with delivery of health care . . . techniques of including the mass media, electronics and audio health museums . . . research and developmen behavioral fields, technology, and community o

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The Health Consumer Education which this committee is asked to facilitate for the nation is a process which could dynamically involve the entire citizenry, and should be oriented toward individual and community action. The focus should be on the whole person in his natural community, and on the individual's needs and responsibilities . . .

> First, to *know* himself, and to shape his life style to maximize his personal options for living fully.
>
> Second, to *utilize* health resources and services and environmental support, with optimal efficiency and economy.
>
> Third, to *participate* constructively in community health and environmental planning, in priority-setting, and in decision-making.

Consequently, the deliberation of this committee should encompass the full range of elements which go into this broad concept of *health consumer citizenship.* The committee's inquiries would probe into such factors as disease, disability, and accident prevention . . . the health care in hospitals, health maintenance organizations, and other health facilities and systems . . . public health, and environmental health, and human ecological consideration . . . exercise, diet and nutrition . . . rehabilitation . . . mental health . . . educational programs and educational aspects of health services in schools, in day-care facilities, in industries, and on farms—and their interrelationships with other community health activities . . . recruiting, training, and career development of health personnel, both those needed for health consumer education services and those concerned with delivery of health care . . . techniques of communication, including the mass media, electronics and audio-visual systems, health museums . . . research and development in social and behavioral fields, technology, and community organization.

Activities of the Committee

To do its job, the Committee:

1. Held eight public hearings in major cities, at which 71 hours of testimony were taken from almost 300 persons from 47 states and Puerto Rico. Witnesses represented groups and organizations in both the private and public sectors that were doing effective health education work, or who had knowledge of the region's health education needs.

2. Met with directors of 22 neighborhood health centers from various parts of the country to learn what they had found out about health education through their work with low-income families and individuals.

3. Asked 600 producers of health education materials and programs to list on a questionnaire their most effective programs as well as their greatest disappointments; plus their view of priorities in health education.

4. Appointed special subcommittees to work directly with business and labor groups, prepayment plans and private insurance companies, professional associations, voluntary health agencies, philanthropic foundations, school health agencies, government and mass media.

5. Commissioned papers from authorities on such subjects as motivation and behavior; school health; educational opportunities in group practice units; health education programs in hospitals; and cost effectiveness of health education programs in industry.

6. Met with 27 federal agencies to determine the potential health education role of government as a majo

7. Examined the experience of the British Foundation and met with representatives of m tries through the World Health Organization to were doing that would benefit this study.

8. Convened special conferences of exp as school health education, motivation and b media to discuss key issues in health educatio

9. Solicited and received written staten from scores of informed individuals and org forth their views of health education proble

10. Distributed more than 15,000 copi describing the mission of the Committee and tion and knowledge which would assist the work.

11. Through the auspices of the Natio which devoted its 1972 National Health Forum Committee, met with the approximately 600 two days to explore their points of view as Committee should take in its work.

12. Committee members and staff me variety of professional organizations and soc the American Medical Association, American M American Public Health Association, America tion, etc., describing the work of the Comm information which would be useful to it in its

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t with 27 federal agencies to determine the potential health education role of government as a major employer.

7. Examined the experience of the British Health Education Foundation and met with representatives of more than 20 countries through the World Health Organization to find out what they were doing that would benefit this study.

8. Convened special conferences of experts in such fields as school health education, motivation and behavior, and mass media to discuss key issues in health education.

9. Solicited and received written statements and reports from scores of informed individuals and organizations setting forth their views of health education problems and priorities.

10. Distributed more than 15,000 copies of a brochure describing the mission of the Committee and soliciting information and knowledge which would assist the Committee in its work.

11. Through the auspices of the National Health Council which devoted its 1972 National Health Forum to the work of the Committee, met with the approximately 600 participants over two days to explore their points of view as to directions the Committee should take in its work.

12. Committee members and staff met and spoke to a variety of professional organizations and societies, among them the American Medical Association, American Nurses Association, American Public Health Association, American Hospital Association, etc., describing the work of the Committee and soliciting information which would be useful to it in its deliberations.

Section I

Changing Needs for Health Education

Until fairly recent times, mankind's most threatening foes were famine and contagion. The first killed millions by starvation; the second by infection. Only since the middle of the 19th century has man been able to fight with reasonable success against those natural enemies. And even in the enlightened last century, the fight has been really successful only in the industrially advanced nations of the world.

While economic and agricultural progress have eradicated famine in most lands, public health physicians have played a major role in controlling infectious diseases by discovering the benefits of purifying water, disposing of sewage, keeping food clean and providing plumbing and sanitation.

Largely because of the reduction in infectious diseases, the average life expectancy of Americans has risen from 47 to 70 years since 1900, while the death rate has been more than cut in half.

Epidemics in the United States once featured such diseases as cholera and smallpox, tuberculosis and influenza, ill-defined fevers and gastro-intestinal disorders. Many children died of scarlet fever, diphtheria and other childhood diseases. Patients by the hundreds languished in hospitals for long periods, for medicine could neither cure the individual nor prevent the epidemics.

Today, communicable disease has almost disappeared from the list of the most common causes of death. In its place, physicians and health educators are faced with new antagonists: diseases caused not by famine or contagion, but by aging, by our sedentary way of life, by nutritional excesses and dietary fads, by urbanization, by changes in the physical environment and by a mobile population whose movements have reduced traditional ties to the community and have compromised the traditional personal acquaintance between patient and physician.

The very success of public health and medical advances, by increasing the life-span, has compounded the problems of chronic and degenerative diseases that are associated with aging. Those diseases now cause more than h
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problem will grow.

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Population density poses many problems for
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As cities grow, complexities in the health fi
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Approximately $75-billion is spent each year o
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sonnel—work in the field, making health care the
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In addition, during the last half-century the nation has changed from a rural to a predominantly urban one. Some 70 per cent of all Americans now live in cities or urban complexes and 80 per cent of us live on little more than five per cent of the land.

Population density poses many problems for health education and health care. It imposes new tasks, demands new relationships and strains all of the resources of public and private agencies.

As cities grow, complexities in the health field grow with them. Moreover, the complexities tend to penalize the ones who require the greatest attention—the economically poor, the undereducated, the aged.

The needs of ethnic and minority groups for faster, easier and cheaper access to the total health care system give health education the dual challenge of (1) educating those citizens to follow desirable personal health practices and (2) developing their ability to find and use the often bewildering array of services that is available.

Health information is dispensed today by many different government and private agencies. But there is little or no coordination of efforts or evaluation of results. No one agency or organization knows what all of the others are doing, and nobody is able to look at results and tell which approach, if any, was successful.

Approximately $75-billion is spent each year on health care. Four and a half million persons—professionals and support personnel—work in the field, making health care the third largest industry in terms of manpower. Health care services are provided in tens of thousands of locations. Yet with all the expenditures, and all the efforts of all the people involved, the nation has not

seen the desired and expected gains in over-all health.

Rates of maternal death and infant mortality, while steadily declining, are still high. The continuing disparity between whites and non-whites in sickness and death rates raises questions about both the quality and the equality of treatment and of access to care.

Helping to keep our morbidity and mortality rates stubbornly higher than they should be are such things as the annual death toll of 50,000 or more from automobile accidents. Dental and visual defects that are routinely reported as among the most common health problems among school children continue to plague individuals of all ages. Some heart disease and circulatory problems can be traced to poor eating habits and lack of exercise. Other factors that contribute to medical problems include drug addiction, air pollution, the effects of crowded and substandard housing, emotional disorders and additional conditions that were either absent or less pervasive in rural America of 50 years ago.

Those and other problems result, at least in part, from failure to involve the individual—and society—in health education. The degree to which each person can play an active and sometimes crucial role in his own health maintenance has not been sufficiently stressed or adequately dramatized.

Controlling the controllable problems and preventing the preventable ones have received relatively little concerted attention. The health care system traditionally has been geared to short-term treatment of acute illness. The average American suffers two episodes of acute illness a year, causing him to seek medical attention and/or resulting in one or more days of restricted activity. But more than 70 per cent of visits to physicians are by the half of the American people who have one or more chronic ailments—heart disease, arthritis, mental or nervous conditions or other long-term impairments that are the most common causes of medical care, disability and death.

Many causes of disease and death can at least be influenced, and some prevented altogether, by good health practices by the individual. The fact is, however, that good health practices are not uniformly followed or even co
persons never think about their health until
symptoms propel them to clinics or hospita
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Fortunately, there are continuing effor
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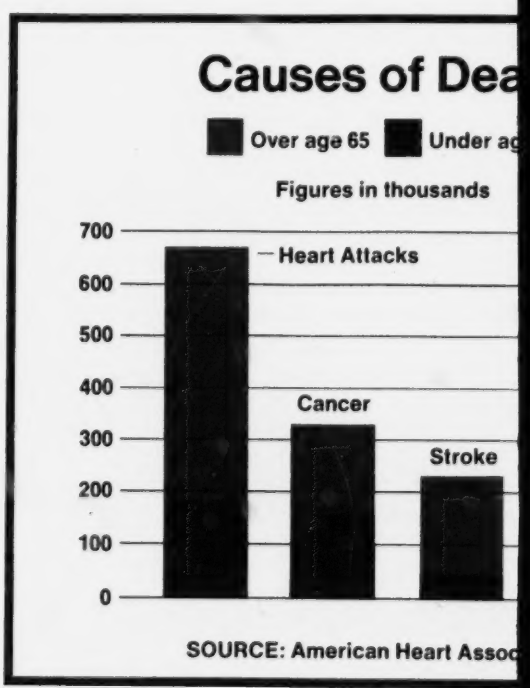


desired and expected gains in over-all health.

s of maternal death and infant mortality, while steadily , are still high. The continuing disparity between whites whites in sickness and death rates raises questions th the quality and the equality of treatment and of o care.

ng to keep our morbidity and mortality rates stubbornly an they should be are such things as the annual death ,000 or more from automobile accidents. Dental and fects that are routinely reported as among the most health problems among school children continue to dividuals of all ages. Some heart disease and circula- lems can be traced to poor eating habits and lack of Other factors that contribute to medical problems rug addiction, air pollution, the effects of crowded and ard housing, emotional disorders and additional condi- were either absent or less pervasive in rural America s ago.

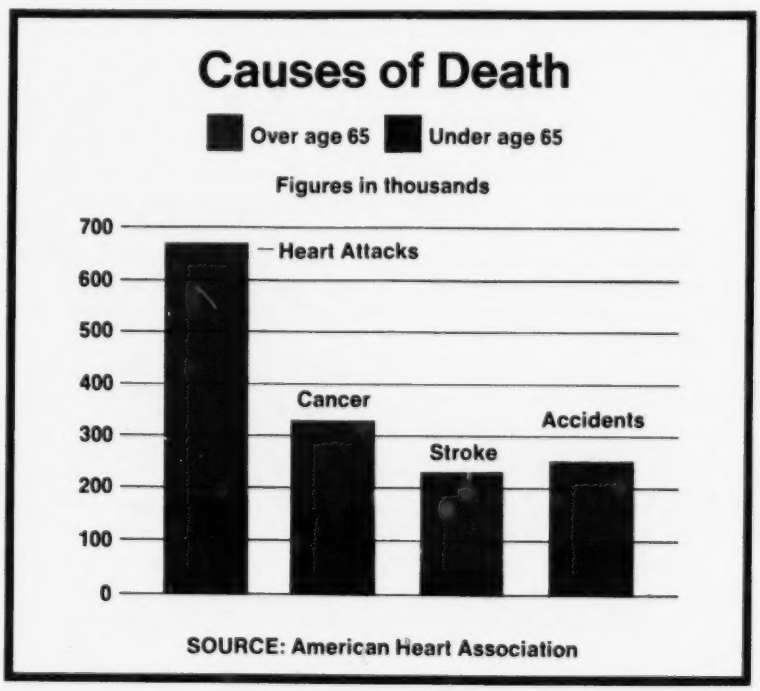
e and other problems result, at least in part, from failure the individual—and society—in health education. The which each person can play an active and sometimes le in his own health maintenance has not been suf- tressed or adequately dramatized.

rolling the controllable problems and preventing the le ones have received relatively little concerted atten- health care system traditionally has been geared to n treatment of acute illness. The average American o episodes of acute illness a year, causing him to seek attention and/or resulting in one or more days of activity. But more than 70 per cent of visits s are by the half of the American people who ha re chronic ailments—heart disease, arthritis, mental onditions or other long-term impairments that are the mon causes of medical care, disability and death.

causes of disease and death can at least be influ- d some prevented altogether, by good health practices dividual. The fact is, however, that good health practices are not uniformly followed or even considered. Millions of persons never think about their health until frightening signs or symptoms propel them to clinics or hospitals for possible emergency treatment.

Fortunately, there are continuing efforts to establish new and more effective health care systems in the United States.

The Committee believes, however, that those efforts will flounder—in spite of careful attention to quality and availability —unless there is a corresponding nationwide effort to change personal attitudes toward health.



Section II
Purposes and Challenges Of Health Education

Changing personal attitudes requires educating people both individually and collectively—not only in terms of personal habits but, just as importantly, in terms of community-wide health "citizenship." Developing health education programs—where virtually none exist now—in schools, offices, factories and homes; forming active neighborhood groups; involving people in the health care process—all are vital parts of good health citizenship.

Efforts to change health behavior must be seen in the same light as efforts to change any other form of human behavior: resistance to change exists; apathy is remarkably strong. That is evidenced by weaknesses in past programs designed to improve behavior with respect to smoking, exercise, weight reduction, drug abuse, use of intoxicants and use of safety devices. Some success has been achieved, but there is a great deal of room for improvement—in large part because where any of those programs have been at least partially effective, the ingredients of success and/or failure have not been sufficiently researched—and even where they have been, the means for making the results widely known have not seemed to exist.

While health education is not a panacea that will solve all health problems, it is undeniably a fundamental part of any logical attack on the problems.

However, in the past, while demand for health care services has been rising, health education has been neglected. The whole field of health education has been fragmented and largely unevaluated. There is no agency inside or outside of government that is either responsible for, or simply assists in, setting goals or maintaining criteria of performance.

One result has been a health care system overburdened with patients who know too little about themselves and the things they could do to prevent illness.

Basic to further discussion of health education at this time is a definition. People tend to confuse health "information" with health "education."

"Health information" is simply facts. And facts are widely available. A national survey by the Louis Harris organization found that the most common sources of inform health are the person's physician, TV advertising, umns in newspapers, medicine sections in magaz news on TV, newspaper and magazine advertising, of health organizations and guidance from the fam

"Health education" is a process that brid between health information and health practices. H tion motivates the person to take the information a thing with it—to keep himself healthier by avoiding are harmful and by forming habits that are beneficia

It is a frustrating paradox, given their relative in effecting change, that while health information year by year in volume and in excellence, health e developed much more slowly.

The public must be made clearly aware of t difference between health information (disseminati health education (persuading people to change the They must also be encouraged to accept the fac education is a longer, costlier, broader, deeper an plicated process.

The health care delivery system can do a great solve health problems. But it cannot do everything. meet it at least half way.

It is the individual whose daily living habits about illness. It is the individual who eats too muc much, rests too little, exercises too little, drives ignores warning signs that tell him he should s attention.

Once he seeks care, it is the individual wh cooperation during or after treatment may blunt t even the greatest of medical skills.

Health habits, attitudes and practices importan the ability of any present or future health care sys its mission. As a 1969 report for the Manpower Adm the Department of Labor put it, the individual's "fail stand, to act or to act wisely can make a mockery to improve other segments of the health system."

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"Health education" is a process that bridges the gap between health information and health practices. Health education motivates the person to take the information and do something with it—to keep himself healthier by avoiding actions that are harmful and by forming habits that are beneficial.

It is a frustrating paradox, given their relative effectiveness in effecting change, that while health information has grown year by year in volume and in excellence, health education has developed much more slowly.

The public must be made clearly aware of the profound difference between health information (disseminating facts) and health education (persuading people to change their lifestyles). They must also be encouraged to accept the fact that health education is a longer, costlier, broader, deeper and more complicated process.

The health care delivery system can do a great deal to help solve health problems. But it cannot do everything. People must meet it at least half way.

It is the individual whose daily living habits often bring about illness. It is the individual who eats too much, drinks too much, rests too little, exercises too little, drives too fast and ignores warning signs that tell him he should seek medical attention.

Once he seeks care, it is the individual whose lack of cooperation during or after treatment may blunt the impact of even the greatest of medical skills.

Health habits, attitudes and practices importantly influence the ability of any present or future health care system to fulfill its mission. As a 1969 report for the Manpower Administration of the Department of Labor put it, the individual's "failure to understand, to act or to act wisely can make a mockery of attempts to improve other segments of the health system."

In essence, making a total health care system work means joint acceptance of responsibility by both the providers of health care and the people they hope to serve. If either group fails to live up to its share of the obligation, total benefits to society will be reduced to that degree.

Health education can play a tremendous role in making that total system work, for it can at the same time stimulate and be stimulated by both parties: health care providers and health care consumers.

An important part of the health education effort is the nation's 25,000 professional health educators—persons with degrees (bachelor's to doctoral) in either school or community health education. But they cannot do the job alone. Good results will require the cooperation of all facets of government, industry, business, health, education, voluntary health and social agencies and other important elements of society.

Their combined activities must be positive. For many years, it was too often assumed that if people were told what was good for them they would take correct action. Some such activity has worked well, as was the response to the voluntary mass immunization against infantile paralysis. Unfortunately, many more programs did not work. Most people who had access to the information continued to behave in the usual manner in spite of the potential threat to their health.

Consequently, the learner—the person to be educated—can no longer be considered merely a recipient of information. He must become actively involved.

Although the problems are huge and diverse, the opportunities for health education have never been greater. One encouraging factor is the continuing rise in the standard of living and level of education of Americans, although neither means better health or better health education automatically.

Generally speaking, however, the more affluent, the better educated, the more sophisticated and the better informed enjoy better health and get better health care. If a person knows what is good and what is bad for him; if he knows how to protect himself and his family; and if he is in a position to take advantage of the best health care available, his chan or premature death are significantly les ignorant, the apathetic, the confused, th or the alienated.

This is not to imply that health educ fined to the latter groups. The benefits o and sophistication favorably affect a pers not only knows what is helpful, but does w

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1. Habit and Attitude Changes

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In this area, ways must be found to help themselves. Without question, it is the health education.

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This is not to imply that health education should be confined to the latter groups. The benefits of affluence, education and sophistication favorably affect a person's health only if he not only knows what is helpful, but does what is helpful.

With those thoughts in mind, the Committee believes the major opportunities in health education lie in the following overlapping areas:

1. Habit and Attitude Changes

This area includes such obvious violations of medical advice as cigarette smoking, faulty diet, lack of regular exercise, drug abuse, excessive use of intoxicants and indifference to safety measures.

They represent a major weakness in the nation's past health education efforts. In the face of programs and campaigns, exhortations, appeals, warnings and even punitive legislation, results have not come close to reflecting the amount of money spent.

In this area, ways must be found to persuade people to help themselves. Without question, it is the most difficult job of health education.

Here we see the collision between information and education. There is every indication that smokers know more about the dangers of tobacco than people who don't smoke—but the information doesn't make them stop. Many fat people know more about the problems of obesity than thin people—but their knowledge does not strengthen their determination to lose weight. Drug abusers know vastly more about its detriments than people who have never tried it—but they continue their abuse in spite of what they know.

All of those people have knowledge; information. What they need is motivation to change their ways.

2. Communicable Disease Control

By contrast, this is one of the more tractable areas of health education. These are measures to protect individuals and communities against microbiological agents of disease; and such actions as water purification, sanitary disposal of human waste, rat control, mosquito control and immunization.

Fortunately, such measures enjoy a high level of acceptability in most areas of the nation. Their lack in some areas is due more to ignorance than to opposition.

These are the measures, in fact, that largely conquered yesterday's communicable diseases, only to see them largely replaced by today's major causes of illness and death which are attributable at least in part to individual behavior.

3. Environmental Protection

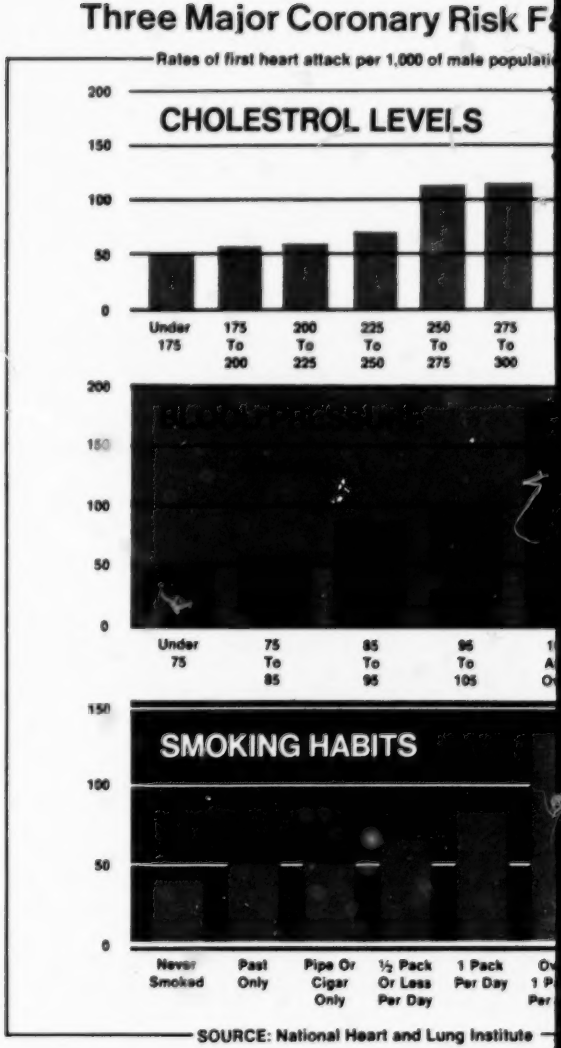
Just as the individual bears some responsibility for many of the medical problems that beset him, so society must accept responsibility for pollution of the air and water, fluoridation or lack of it, noise pollution, radiation, pesticide exposure, fabric flammability, hazardous toys and games and vulnerability to diseases through occupations.

A clean, healthy environment does not come easily, nor does it come free. But where collective action has been taken, and where industry and the public at large have both been willing to accept their share of the solution and to bear their share of the cost, polluted rivers are getting fresher, undue noise is being reduced, goods and materials are being redesigned for safe use and factories are installing smoke-abatement mechanisms.

4. Seeking Medical Help and Following Medical Advice

To maintain reasonably good health, all persons should be informed about the early signs of serious disease, and about action to take when they occur or persist. This requires initiatives by physicians and other elements of the health care system.

As important as knowing when to seek medical help is knowing how to manage certain diseases that require special regimens. Such management includes the frequency with which



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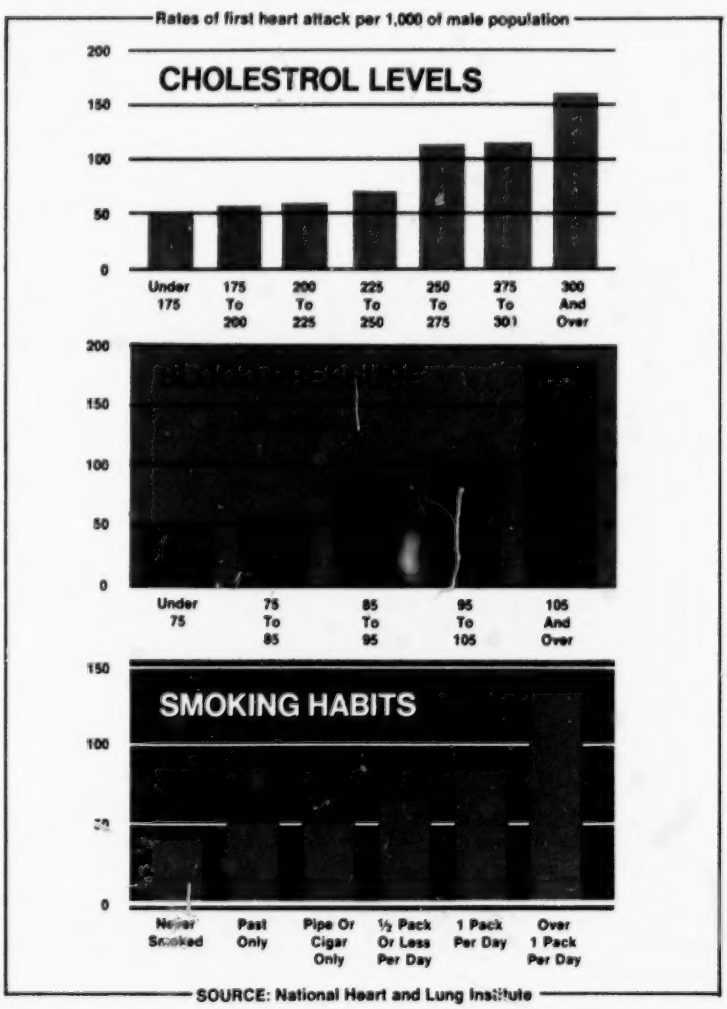
Three Major Coronary Risk Factors



medications are taken, rules about diet and/or exercise and the whole problem of the patient's social and emotional adaptation to his condition. For example, a patient's personal management of such chronic conditions as diabetes, hypertension, asthma, etc., is of crucial importance to recovery or livable maintenance.

A well-motivated and educated patient, equipped to help in the solution of his own medical and psychological problems, will most likely not become a delinquent—and more seriously ill—patient.

5. Education Through Planning and Participation

The final element in a multi-level approach is the need to encourage and support the planning and development of health facilities—and health education programs—with the active participation of people who will be their ultimate users. Such participation is perhaps the most effective way for people to learn. Low-income families who have helped to plan neighborhood health centers, for example, have not only become more knowledgeable themselves, but have proved adept at getting good health information to their neighbors.

* * *

In addition to approaching those areas, it is also important that health education be custom-designed to reach special audiences with special messages.

There are large groups which have unique needs in health education which differ from the normal needs of the general public.

1. Low-Income Families

The ill health of the poor requires widespread relief. Too many do not know how to care for themselves, or do not have the wherewithal, even if they have the knowledge. Some do not always know the benefits to which they are entitled now, such as Medicaid or clinical prenatal care for pregnancy. A significant number do not know how to deal with the complexities of clinics, outpatient departments, hospitals and physician specialists.

The community has an obligation to teach them how to get the care they need, as well as how to avo
often.

Many of their health problems, of course
outside their control and outside the rang
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tion, lack of employment, etc.

Their problems are social as well as
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With all of those factors at work, the
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2. Mothers

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mmunity has an obligation to teach them how to get the care they need, as well as how to avoid needing care as often.

Many of their health problems, of course, stem from sources outside their control and outside the range of medicine—bad housing, bad sanitation, poor nutrition, poverty, lack of education, lack of employment, etc.

Their problems are social as well as medical, and the solutions lie in all of society as well as in the medical and health care field.

With all of those factors at work, the poor suffer medical problems caused by malnutrition; they have a higher rate of infant mortality; they experience a higher proportion of emotional, nervous and mental disorders; and their children have many more accidents involving burns or poisoning. In addition, bad housing and overcrowded and unsanitary conditions contribute to greater incidence of rheumatic fever, rheumatic heart disease, common respiratory diseases and complications such as middle-ear infection and meningitis.

Poverty might be likened to a hereditary disease in that children of the poor die earlier and in greater numbers; succumb more easily to childhood ailments; and more often become permanently incapacitated for school or employment—thus adding to the pool of poverty and unemployment that exacts a high price not only from its victims, but from all citizens.

2. Mothers

Mothers are a primary audience for effective health education because from pregnancy through her children's adolescence, a mother's knowledge and attitude about health are the greatest influence on the physical well-being of her entire family.

Her roles as manager, nurse and dietician shape and direct the family's health patterns more than any other combination of factors.

However, even with the best of intentions and the most solicitous attitude toward the welfare of her husband and children, a mother's lack of basic knowledge or of intent—especially in dietary matters—may have consequences that are injurious to her family.

3. School Children and Teenagers

The quality—even the existence—of health education in the classroom varies greatly throughout the country. Antiquated laws, indifferent parents, unaggressive school boards, teachers poorly equipped to handle the subject, lack of leadership from government or the public, lack of funds, lack of research, lack of evaluation—all of those hobble a comprehensive program that could provide the nation's 55-million school children (one-fourth of the entire population) with adequate health education of an interesting, pertinent and objective nature.

While large amounts of so-called health information materials find their way into the schools, because they are free or inexpensive, such materials are rarely evaluated in terms of real value to the children. Often their use is based on their easy availability to the teacher—who sees that many are sponsored by reputable firms and assumes that they are effective.

Testimony before this Committee showed that the quality of much health information material is questionable. Many materials are not pre-tested for intended audiences or evaluated by qualified experts. And much of it is outdated.

Our findings are that school health education in most primary and secondary schools either is not provided at all, or loses its proper emphasis because of the way it is tacked onto another subject such as physical education or biology, assigned to teachers whose interests and qualifications lie elsewhere.

Evidence abounds that health education in schools is not effective, even when it is attempted. Nutrition studies show that teenagers, especially girls, often damage their own health and deprive themselves of vitality because of poor eating habits. Youngsters who once urged their parents not to smoke have become cigarette smokers as teenagers. And, of course, the high and rising incidence of venereal disease and the spread of drug abuse among teenagers are two other of the most urgent reasons for assigning a special priority to health education among school children.

4. Middle-Aged Middle Class

Obesity, smoking, sedentary lifestyle and lack of sufficient exercise, excessive consumption of alcohol an sugar, high-cholesterol food all take a large to gory of people.

A report to the White House Conference on out that while middle-income families spend $ food each year, 37 per cent are poorly nour too thin.

Nutrition surveys confirm the paradox of m affluence.

5. Chronically Ill and Aged

These people have a variety of special ne palliative measures, rather than curative ones, most of their problems.

While relatively little can be done by health to relieve their plight, special programs shou offer the most compassionate counseling, both comfort and of the ways in which they can be problems they have.

* * *

One in five high school students will get V.D. before they receive their diploma, but most school health textbooks do not mention the subject, and some State legislatures do not permit the subject to be taught in school.
SOURCE: Testimony, Los Angeles Regional Hearings.

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Middle Class

noking, sedentary lifestyle and lack of sufficient exercise, excessive consumption of alcohol and too much high-sugar, high-cholesterol food all take a large toll from this category of people.

A report to the White House Conference on Nutrition pointed out that while middle-income families spend $2,500 or more on food each year, 37 per cent are poorly nourished—too fat or too thin.

Nutrition surveys confirm the paradox of malnutrition amidst affluence.

5. Chronically Ill and Aged

These people have a variety of special needs in that only palliative measures, rather than curative ones, are available for most of their problems.

While relatively little can be done by health education alone to relieve their plight, special programs should be devised to offer the most compassionate counseling, both in terms of their comfort and of the ways in which they can best cope with the problems they have.

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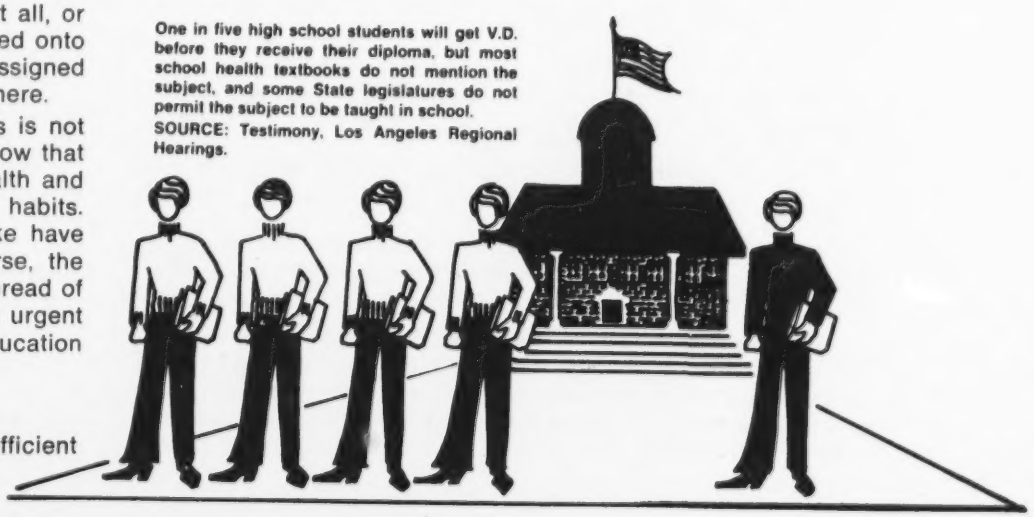

Medical advancements coupled with broad-based achievements in health education have the potential of creating a standard of well-being higher than the nation has ever known.

Three factors now exist which lead to optimism regarding the attainment of that potential: (1) recognition by the President of the need to focus attention on the role of health education; (2) findings of the Committee which indicate a growing awareness among the nation's people of the ne directed health education programs; and body of knowledge that is essential to the education activities, and the Committee's be organization is prepared or equipped to dr the importance of or push for the coalescen forces, public and private, in support of its a

Section III

Findings and Recommendations: National Activities in Support Of Health Education

In view of the potentially vast benefits to come from improved and widespread health education, the Committee's principal recommendation is that a new organization be established: the "National Center for Health Education."

The Center would be a private, nonprofit organization having a mandate from the government (authorized by the Congress), financed by both the federal government and private sources.

The form, functions, financing and management of the Center will be described in detail in Section IV of this report.

First, however, it is necessary to establish a foundation upon which the Center would be based; a foundation of facts and findings that justify its need.

This digression, based on testimony and other inputs described earlier, is included because the Committee wishes to point out that the activities about to be described could and should be carried out even if the Center were not established. Health education programs in this nation cannot all come from one source, no matter what it might be.

However, the activities listed in this Sec ized and carried out better and more effec national Center to stimulate and to encourag by other organizations and institutions in th move the nation into action, and to observ education scene in order to monitor, evaluat the multiple efforts being undertaken.

The Committee sees a compelling need f in relation to all of the following areas:

Health problems.

Age groups.

Health care delivery system.

Schools and colleges.

Employment.

In addition, we shall have some things t education services and leadership.

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eing higher than the nation has ever known.

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nt of that potential: (1) recognition by the President
o focus attention on the role of health education;
f the Committee which indicate a growing aware-
ness among the nation's people of the need for competently directed health education programs; and (3) the expanding body of knowledge that is essential to the success of health education activities, and the Committee's belief that no existing organization is prepared or equipped to dramatize continually the importance of or push for the coalescence of all pertinent forces, public and private, in support of its accomplishment.

Section III

Findings and Recommendations: National Activities in Support Of Health Education

of the potentially vast benefits to come from im-
idespread health education, the Committee's prin-
endation is that a new organization be established:
Center for Health Education."

er would be a private, nonprofit organization having
om the government (authorized by the Congress),
oth the federal government and private sources.

, functions, financing and management of the
described in detail in Section IV of this report.

ever, it is necessary to establish a foundation upon
nter would be based; a foundation of facts and
ustify its need.

ession, based on testimony and other inputs
ier, is included because the Committee wishes to
the activities about to be described could and
ried out even if the Center were not established.
ion programs in this nation cannot all come from one source, no matter what it might be.

However, the activities listed in this Section can be organized and carried out better and more effectively if there is a national Center to stimulate and to encourage health education by other organizations and institutions in the country; to help move the nation into action, and to observe the entire health education scene in order to monitor, evaluate and communicate the multiple efforts being undertaken.

The Committee sees a compelling need for health education in relation to all of the following areas:

Health problems.

Age groups.

Health care delivery system.

Schools and colleges.

Employment.

In addition, we shall have some things to say about health education services and leadership.

Health Problems and Health Education

FINDINGS

Although many of the major causes of illness and death can be affected by individual behavior, health education is a neglected, under-financed, fragmented activity with no agency inside or outside of government responsible for establishing short- or long-term goals.

Virtually no component of society makes full use of health education. That includes the health care delivery system, the educational system, voluntary health agencies, business and labor, prepayment plans and the insurance industry, mass media and others. It is obvious from testimony and other information furnished to the Committee that each one could contribute substantially to the nation's health education.

A strong catalytic force—to keep the fires burning under the problems—such as the Center, might well provide the effort needed to help each part of the system get programs going, or to get better results from what it is already doing.

The need was repeatedly cited to find and try new kinds of health education programs tailored to specific kinds of health problems.

RECOMMENDATIONS

That health problems based on behavior—or which can be worsened or bettered primarily through behavior—be identified and made the basic content of health education programs. And that guidelines be developed for each that can be followed by a person alone or with the help of a health adviser.

That extended and intensified health education programs be developed for appropriate groups in every community to focus on health problems which apparently can be prevented, detected early or controlled through individual action.

That cost analysis studies be made to determine the long-term effectiveness of health education programs in reducing personal health care costs for persons with specific types of health problems.

Age Groups and Health Education

FINDINGS

Witnesses and consultants repeatedly
Committee the importance of providing health
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the crucial importance of the first 10 years of li
are critical in laying the foundation for future
effectiveness of the nation's people. Without
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they are eligible for any kind of assistance.

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paints a less than favorable picture of the
health education.

No age segment can be ignored by heal
grams, because no segment is immune to haz
interfere with good health.

RECOMMENDATIONS

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munity to help people locate the source of wh
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Age Groups and Health Education

FINDINGS

Witnesses and consultants repeatedly expressed to the Committee the importance of providing health education for all people of all ages. However, a number of witnesses emphasized the crucial importance of the first 10 years of life. The early years are critical in laying the foundation for future productivity and effectiveness of the nation's people. Without a population of vigorous people concerned with the maintenance of their health, no nation can thrive.

Through school as well as other sources—nursery school, head-start programs and the like—young children must be helped to become responsible citizens who care enough about themselves to care also about others. Such programs, so far as the Committee could determine, are almost entirely missing from elementary school curricula today.

Other age groups, in various situations, also need special attention. Aside from what they might be learning in school, children in cities might not know about recreational opportunities in their neighborhoods; teenagers in urban or rural areas might not know how to prevent venereal disease, or where to get treatment; unwed pregnant girls in any location might not know where help is available; older people, as already mentioned, might not know what their health benefits are or whether they are eligible for any kind of assistance.

The evidence of a large health information gap, coupled with the need to motivate people toward positive health behavior, paints a less than favorable picture of the existing state of health education.

No age segment can be ignored by health education programs, because no segment is immune to hazards which might interfere with good health.

RECOMMENDATIONS

That information services be made available in every community to help people locate the source of whatever health care services they need.

That people of all ages have opportunities to participate in comprehensive health education programs.

That priority be given to research into human motivation as it relates to influencing the quality of health habits and practices.

That special attention be given to motivational factors which influence the health behavior of children during their first 10 years.

That people of the community be invited to play a larger role in setting policy and planning health education programs affecting their own welfare. Experiences shared with the Committee indicated strongly that a person's motivation and behavior with respect to health is favorably influenced by involvement in the planning of programs for himself and for others.

It is equally important that health education programs be designed to address the cultural mores and intellectual level of each group being approached. Health education efforts so far have generally been stereotyped. There is need for innovation and experimentation with new kinds of educational approaches and programs for various kinds of people. Among people of recent foreign extraction, or of poverty, or of poor education, simplistic approaches will not only be ineffective and meaningless, but may also be counter-productive.

The Health Care Delivery System and Health Education

FINDINGS

The nation appears to be on the eve of major new legislation covering the delivery and financing of health care. With or without a federal program of protection, health education should be interwoven into the very fabric of health care.

The Committee heard from many people that providing health education would be largely futile unless at the same time the health care system is modified to permit easier access. Conversely, however, providing health care would be largely futile unless at the same time health education is provided on a nationwide basis.

At the present time, health education is hardly a brush-stroke on the total picture of health care a industry.

Of $75-billion spent last year for me health care—more than $200-million a day—a spent for treatment after illness occurs. Of t half is spent for biomedical research. Preve programs of health education split the ba education getting the short end.

Federal and state government commitm cation is hardly visible. Of $18.2-billion all medical and health activities in the Departm $30-million is spent for specific programs in and $14-million more for general programs less than one-fourth of one per cent for heal

Of an additional $7.3-billion allocated f to all other federal agencies, even a smalle for health education.

On a state and territorial level health less than one-half of one per cent of their education.

Legislation exists which actually impede of effective school health programs. Some books regarding what can be taught have since the late 1800s. In other states, needed le

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RECOMMENDATIONS

That a focal point be established within HEW to work with all federal agencies to hel government's involvement in health education more efficient.

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Of $75-billion spent last year for medical, hospital and health care—more than $200-million a day—about 92 per cent is spent for treatment after illness occurs. Of the rest, more than half is spent for biomedical research. Prevention of illness and programs of health education split the balance, with health education getting the short end.

Federal and state government commitment to health education is hardly visible. Of $18.2-billion allocated in 1973 for medical and health activities in the Department of HEW, only $30-million is spent for specific programs in health education; and $14-million more for general programs. That amounts to less than one-fourth of one per cent for health education.

Of an additional $7.3-billion allocated for health purposes to all other federal agencies, even a smaller fraction is spent for health education.

On a state and territorial level health departments spend less than one-half of one per cent of their budgets for health education.

Legislation exists which actually impedes the development of effective school health programs. Some of the laws on the books regarding what can be taught have not been changed since the late 1800s. In other states, needed legislation is lacking.

Attitude surveys reveal that most Americans are less informed than they realize about health matters. The vast majority —88 per cent in one study—say they look to their physicians or to television commercials for information about health. However, testimony and other information indicate that most physicians are too busy to do an effective job of health education and television commercials are more concerned with product promotion than with true consumer health education.

RECOMMENDATIONS

That a focal point be established within the Department of HEW to work with all federal agencies to help make the federal government's involvement in health education more effective and more efficient.

That consumers be more adequately informed about the real health value of products and services; and that more rigid protection be given to consumers against harmful or worthless products that are presented as having positive health values.

That when it is demonstrated that individual behavior will not assure that people follow good health practices—which risks the health or safety of others—the Congress and/or industry and others mandate such practices. An example would be requiring inoculation against contagious disease before allowing a person to enter school or go to work.

That the government, prepayment plans and insurance companies, which pay for health care services for others, be willing to adjust premium rates to include in their payments the cost of health education for the patients involved.

That the nation's hospitals be strongly encouraged to offer health education programs to patients and families—both on an inpatient and outpatient basis. Similarly, that more extensive health education—focused on the needs of the patient—be provided by physicians and allied professionals in their personal contacts with patients. The lack of health educational programs in hospitals and physicians' offices is tragically prominent at the present time.

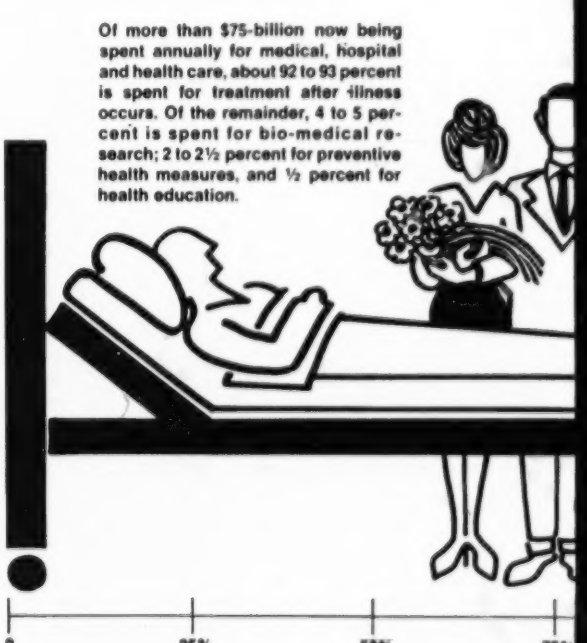
That a major educational program be undertaken among medical and health professionals and administrators to prepare them psychologically and professionally to accept and respond creatively to increasingly expressed concerns for consumer participation in the design of health education programs and even of health care facilities.

That skill in providing health education be an essential part in the training and continuing education of all health workers.

That systematic research and evaluation be a part of all health education programs within the health care delivery system.

That various health educational approaches among patients be tested to determine the ones which appear to bring about the best results in patient improvement and in reduction of need for health services.

That health educators work with consumers, munity, with health care administrators and plan to help determine the location of new health ca scheduling service hours; and in developing proc of services that will reflect the health care needs a tions of the people to be served.


Of more than $75-billion now being spent annually for medical, hospital and health care, about 92 to 93 percent is spent for treatment after illness occurs. Of the remainder, 4 to 5 percent is spent for bio-medical research; 2 to 2½ percent for preventive health measures, and ½ percent for health education.
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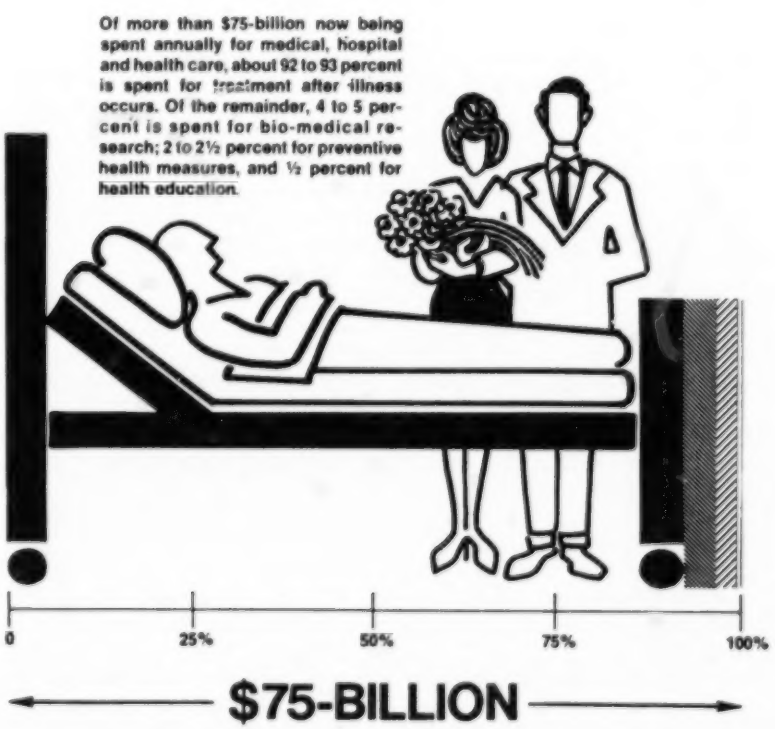
That health educators work with consumers and the community, with health care administrators and planning agencies to help determine the location of new health care facilities; in scheduling service hours; and in developing procedures for use of services that will reflect the health care needs and living conditions of the people to be served.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Schools and Colleges and Health Education

FINDINGS

A cherished American ideal is that each child will have the chance to develop his potential to the fullest. If the future well-being of the nation rests on the realization of that ideal, it follows that education for personal health and health citizenship among today's children and youth should have high priority.

Although the educational system is predominantly for the young, it provides learning for all ages. Currently, 75-million Americans are enrolled in preschool, school, college and continuing education programs.

The trend is toward greater enrollment in preschool programs, and schools are taking younger children. At the same time, head-start, nursery school, day care and a host of other programs are being established. Of the 11-million children between the ages of three and five, an estimated four million are enrolled in such programs. That points up opportunities for health education. However, there has been little effort to bring together the fields of health education, parent education and early childhood education for planning and evaluation.

The largest portion of those enrolled in educational programs—almost 59 million—are in elementary and secondary schools (grades K through 12). The Committee found that while some children have an opportunity to participate in comprehensive school health education programs, most do not. In the latter case, health education either is not provided at all or is fragmented—lacking in planning, scope, sequence and evaluation; and lacking in commitments of time, money, administrative support and legal sanction.

Despite the fact that the Committee found that school health education programs are grossly inadequate, the U.S. Office of Education (Department of HEW), in a report prepared for the Committee, could not cite a single program of research or evaluation which it is supporting in the area of school health education.

Almost nine-million students are enrolled in colleges. If appropriate health education can be provided during such a significant period of growth, dividends can result for society in terms of personal, family and communit
Many college students, for the first time, ar
of assuming nearly total responsibility for
with preparing for their future roles as pare

More than 10-million adults are enrolle
cation programs. That important and gro
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RECOMMENDATIONS

That a series of national and regional
to (1) identify leadership in the health educ
tion and early childhood education fields; (
and future health education needs and in
children; (3) more fully describe existing h
grams for preschool children; and (4) explo
directions for legislation, program develop
assure that preschool children and their pa
expanding health education programs.

That adoption of model state laws for s
tion be encouraged in every state, covering
selves, teacher preparation, evaluation of re

That the feasibility of matching state
funds be explored to support school health

That periodic surveys determine the hea
and interests among pupils and students fro
college, for use in planning and developi
programs.

That the Department of HEW and/or its
be urged to initiate systems of research
projects in school health education.

Employment and Health Education

FINDINGS

For health education purposes, a good
adults is through their place of employment
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Colleges and Health Education

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nine-million students are enrolled in colleges. If ealth education can be provided during such a riod of growth, dividends can result for society in terms of personal, family and community health citizenship. Many college students, for the first time, are faced with the task of assuming nearly total responsibility for their own health and with preparing for their future roles as parents and citizens.

More than 10-million adults are enrolled in continuing education programs. That important and growing segment of the educational system is virtually untouched by health education.

RECOMMENDATIONS

That a series of national and regional conferences be held to (1) identify leadership in the health education, parent education and early childhood education fields; (2) determine present and future health education needs and interests of preschool children; (3) more fully describe existing health education programs for preschool children; and (4) explore ways to chart new directions for legislation, program development and research to assure that preschool children and their parents are involved in expanding health education programs.

That adoption of model state laws for school health education be encouraged in every state, covering the programs themselves, teacher preparation, evaluation of results, reporting, etc.

That the feasibility of matching state funds with federal funds be explored to support school health education programs.

That periodic surveys determine the health education needs and interests among pupils and students from preschool through college, for use in planning and developing health education programs.

That the Department of HEW and/or its Office of Education be urged to initiate systems of research and evaluation of projects in school health education.

Employment and Health Education

FINDINGS

For health education purposes, a good place to reach many adults is through their place of employment since 40 per cent of the population is working. Employees who are knowledgeable about health and who are motivated to prevent illnesses and

accidents are an asset to themselves, their employers, their families and the nation.

The health of employees directly affects the employer's insurance and medical costs, which have been rising. Business costs go up when there are absences because of extra training expense and productivity losses. Evidence presented to the Committee indicates that employed Americans lose an average of seven and a half days of work per year because of reported illnesses and accidents, many of which are preventable. That amounts to 600-million man-days per year. Any reduction in that figure through health education could have a significant impact not only on productivity, wages and profits but, more important, on a healthier life for many families.

While health education is not a total answer, it does have the potential of favorably influencing the morale and productivity of employees.

Employers and labor organizations have long been concerned about industrial safety and occupational health hazards and have developed effective programs in those areas. In addition, more and more employers have become concerned with acute, work-related problems such as alcohol and drug abuse.

Involvement of business, industry and labor in school and community health affairs as well as in plant programs, can contribute to sound off-job safety and health practices that can also benefit on-job attendance and productivity.

RECOMMENDATIONS

That the federal government, as the nation's largest employer, serve as a model for industry by building health education into existing programs and by allocating funds for health education specialists.

That all business, industry and labor organizations be encouraged through tax incentives and other means to plan, undertake and evaluate comprehensive health education programs for their employees, members and families.

That business, industry and labor encourage and support basic research to determine the effectiveness of health education in (1) increasing the quality of life; (2) reduc
from work; and (3) increasing productivity at wo

Health Education Services

FINDINGS

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SOURCE: Testimony, H.E.W

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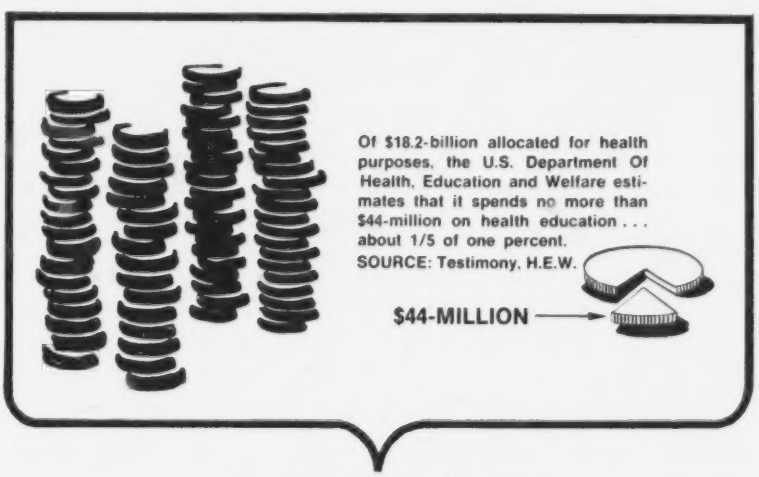
Health Education Services

FINDINGS

In the United States today, there are approximately 25,000 professional health educators—persons with specialized training in either school or community health education. The total is inadequate in view of the nation's growing efforts to mount a comprehensive nationwide health education program. Additional health education manpower will require training while existing manpower will need retraining or redirection.

The report of the Subcommittee on School Health Education indicated that accreditation systems for health education programs at undergraduate and graduate levels need to be extended.

And with the advent of increasing numbers of allied personnel who are performing health education tasks, it is essential


Of $18.2-billion allocated for health purposes, the U.S. Department Of Health, Education and Welfare estimates that it spends no more than $44-million on health education . . . about 1/5 of one percent.
SOURCE: Testimony, H.E.W.
$44-MILLION
$18.2-BILLION

to re-examine the roles of both health educators and allied personnel.

The value of parents—the first "health educators"—and of neighborhood health workers and volunteers must not be overlooked or minimized. It is obvious that health educators at all levels of training and experience need to be mobilized.

As mentioned earlier in this report, the Committee uncovered a great need for more skilled health education programs and leaders in preschool and school classes, and in hospitals and physicians' offices.

RECOMMENDATIONS

That schools of medicine, health science and public health cooperate with schools of education to qualify administrators and teachers to perform and administer health education programs. Since every health education program obviously cannot be run by a professional health educator, serious consideration should be given to preparing selected persons as "paramedics," in effect, in the field of health education.

That the nation's voluntary health agencies consider special programs to convert their loyal and efficient volunteers into effective health educators as well. That would require special commitment and training, and would likely result in a more effective volunteer force that would do a vitally needed job.

Because access to health services is persons by social, economic or geographic *the control of the health care system, that sy field of health education should encourage ev make possible a fuller utilization of existin persons who need them. In other words, that education be to give people basic inform rights to health care services and how to get*

Leadership for Health Education

FINDINGS

One principal weakness in health educa still-evolving status of the health education p lack of a focal point for health education in and at state and national levels.

RECOMMENDATIONS

That a focal point for health education each locality through "Community Health Edu coordinate and help improve health educatio the area.

That each state consider the feasibility "Council on Health Education" to consider th scope, functions, organization and financin focus on health education.

Section IV
Findings and Recommendations: National Center for Health Education

As our primary finding, we believe very strongly that the nation needs a National Center for Health Education to stimulate, coordinate and evaluate health education programs. At the present time, there is no organization or agency in or outside of government even approaching it. Nor does a the horizon to indicate that the need for a Ce in some other way.

The over-all objective of the National C

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Because access to health services is reduced for many persons by social, economic or geographic conditions beyond the control of the health care system, that system and the total field of health education should encourage every step that would make possible a fuller utilization of existing services by all persons who need them. In other words, that one role of health education be to give people basic information about their rights to health care services and how to get them.

Leadership for Health Education

FINDINGS

One principal weakness in health education has been the still-evolving status of the health education profession and the lack of a focal point for health education in most communities and at state and national levels.

RECOMMENDATIONS

That a focal point for health education be established in each locality through "Community Health Education Centers" to coordinate and help improve health education programs within the area.

That each state consider the feasibility of establishing a "Council on Health Education" to consider the most appropriate scope, functions, organization and financing for a statewide focus on health education.

Section IV
Findings and Recommendations: National Center for Health Education

ur primary finding, we believe very strongly that the eds a National Center for Health Education to stimulate, e and evaluate health education programs. At the pres- there is no organization or agency in or outside of government even approaching it. Nor does anything appear on the horizon to indicate that the need for a Center might be filled in some other way.

The over-all objective of the National Center would be to

improve the health of the American people through health education. It would approach that goal by continuing and vastly expanding the work of the Committee in determining exactly what is being done now in health education; how well it is being done; how more can be done; and how what is done can be made to deliver results.

The Committee considered a number of other ways to provide the same central prodding and monitoring of health education—broadening the activities of the National Health Council; reviving the American National Council for Health Education of the Public; creating an organization similar to the National Science Foundation; establishing a Council of Health Advisors to the President; and lodging the entire responsibility with the Department of HEW. All of those were rejected in favor of a National Center.

As stated in the previous section, the Center would be a private, nonprofit organization authorized by the Congress and financed by both the federal government and private sources.

It is important to note, too, that while the Center would be a source of information and expertise for lawmakers, as well as for the rest of society, it would not conduct lobbying at either state or national levels.

Its operations, management and methods of financing are explained in the rest of this section.

Functions of the Center would be carried out by five operating divisions:

Division for Research in Health Education

The division would support research and encourage others to support research in health education. Its primary functions would be to:

1. Determine what health education research is now being done.

2. Determine the kind of health education research that ought to be done to find ways to overcome existing problems.

3. Rank the needed research projects in order of priority; initiate or stimulate studies that are not being made; and help support those that are already under way.

4. Provide consultation to persons who nee
paring research proposals or in actually conduc

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new information, much of which is useful in dai
made known to the public and if the public is
what to do with it. Health education research mu
gaps of understanding that often exist between
educators, and between educators and the public.

The most important research of the entire pro
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styles in order to enhance the quality of their lives

Division for Demonstration Programs in Health Educ

The division would seek to enhance the re
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programs of health education. Its objectives wou

1. Survey the needs, interests, attitudes, k
behavior of the American public regarding health.
be made on a continuing basis.

2. Use the findings of the surveys to help
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izations and of community organizations.

3. Support demonstration programs in hea
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education needs.

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support those that are already under way.

4. Provide consultation to persons who need help in preparing research proposals or in actually conducting research.

Medical and social scientists are continually discovering new information, much of which is useful in daily living if it is made known to the public and if the public is clearly shown what to do with it. Health education research must help fill the gaps of understanding that often exist between scientists and educators, and between educators and the public.

The most important research of the entire program is to find ways to persuade people of varying lifestyles to modify those styles in order to enhance the quality of their lives.

Division for Demonstration Programs in Health Education

The division would seek to enhance the results of health education by supporting and encouraging new and imaginative programs of health education. Its objectives would be to:

1. Survey the needs, interests, attitudes, knowledge and behavior of the American public regarding health. Surveys would be made on a continuing basis.

2. Use the findings of the surveys to help plan programs of the National Center, of other national health education organizations and of community organizations.

3. Support demonstration programs in health education that represent broad cross sections of people; which focus on objectives that are measurable; and that emphasize the prevention or moderation of illness or accidents which appear controllable through individual behavior. The purpose of the demonstrations would be to motivate individuals and whole communities to accept responsibility for meeting their own health education needs.

4. Provide consultation to organizations that request help in planning or evaluating health education programs.

Clearing House for Health Information and Education

The division would be a clearing house for health information and education programs, including data on existing pro-

grams regarded as effective, as well as printed materials, graphics, audio-visuals and others. It would:

1. Survey existing health information data systems and tie into them wherever possible; encourage further development of existing data systems; support the development of new ones, where needed; and work to coordinate the efforts of all major groups involved in health information data systems.

2. Make health information available to the public and to organizations involved in health education.

3. Continually evaluate the effectiveness of existing health information and health education services to enhance their scope and quality.

4. Encourage pre-testing and expert evaluation of health information materials produced by others. An efficiently run Center would become a source to which companies and organizations producing health information material would turn voluntarily for evaluation and expert help.

Division for Communications in Health Education

The division's purpose would be to develop two-way communications (a) between the Center and providers of health education services, and (b) between the Center and the nation's mass media. It would:

1. Hold regular working conferences to bring together the major national health education organizations. Included would be the professional health educators plus other organizations with health education programs. Purposes of the conferences would be to share ideas; identify gaps and overlaps in health education programs and research; and find ways in which the organizations could cooperate to make everyone's efforts more effective.

2. Find ways in which the mass media—newspapers, magazines, radio, television and motion pictures—and the Center can cooperate to provide the best possible public service programming in health education.

3. Establish the National Center as a source of information and expertise which can be used in planning and creating both commercial and noncommercial material in magazine articles, newpaper stories, radio grams and motion picture features.*

Division for Community Health Education Cent

The division would encourage the est munity centers for health education. Loca assisted by the National Center. Communit set up in response to interest and need groups. (Planning committees which arran for the Committee might become the nuc organized to establish community centers.)

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It is obvious from the brief descriptio divisions that the success of the Center lies closely with both the providers and the r education. It cannot function in a vacuum. I those who are providing health information and at the same time reach out to people wh tion and the education.

Management of the Center

The Committee recommends a board of sons, appointed by the President and confir They should represent major groups conc representatives of the public, government, la industry, health and health education profes tions, voluntary health organizations, insuran carriers and others.

Persons appointed should be convinc value of health education and willing to e directions in educating the nation's people desirable health habits.

The staff of the Center should be heade tive officer who would act as the link betw

*See Supplementary Statement by C. Wrede Petersmey

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tablish the National Center as a source of information tise which can be used in planning and creating both commercial and noncommercial material in health education—magazine articles, newpaper stories, radio and television programs and motion picture features.*

Division for Community Health Education Centers

The division would encourage the establishment of community centers for health education. Local centers would be assisted by the National Center. Community centers would be set up in response to interest and need expressed by local groups. (Planning committees which arranged public hearings for the Committee might become the nuclei of local groups organized to establish community centers.)

* * *

It is obvious from the brief descriptions of the operating divisions that the success of the Center lies in its ability to work closely with both the providers and the recipients of health education. It cannot function in a vacuum. It must reach out to those who are providing health information or health education; and at the same time reach out to people who need the information and the education.

Management of the Center

The Committee recommends a board of directors of 25 persons, appointed by the President and confirmed by the Senate. They should represent major groups concerned with health—representatives of the public, government, labor, commerce and industry, health and health education professions and associations, voluntary health organizations, insurance and prepayment carriers and others.

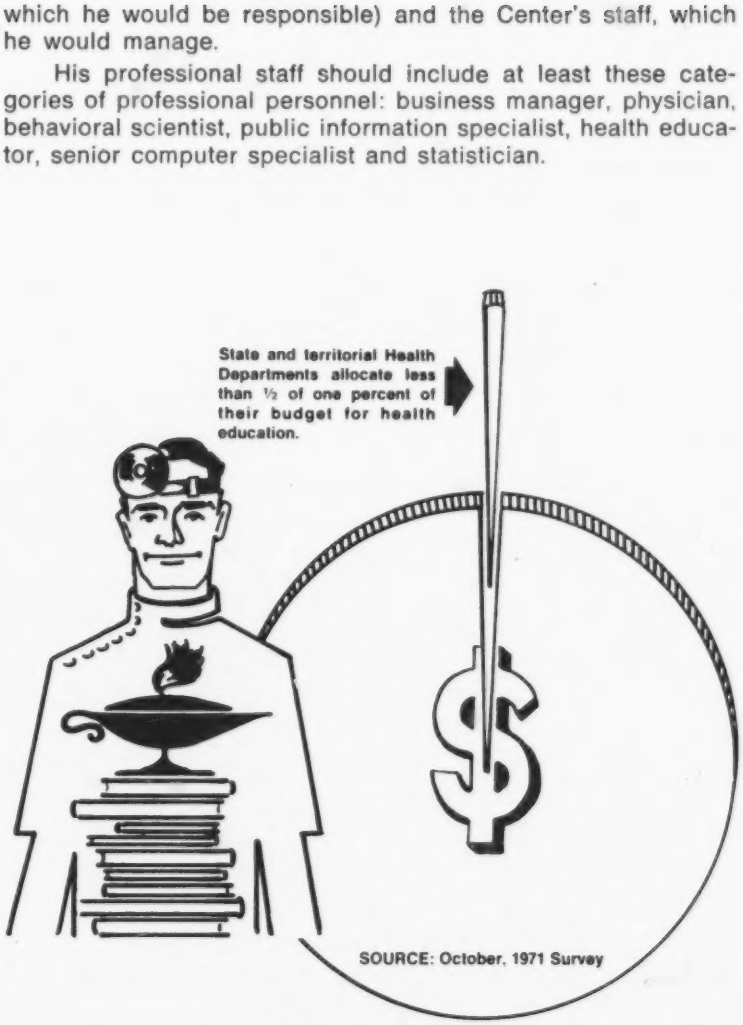
Persons appointed should be convinced of the potential value of health education and willing to explore entirely new directions in educating the nation's people about health and desirable health habits.

The staff of the Center should be headed by a chief executive officer who would act as the link between the board (to

*See Supplementary State ent by C. Wrede Petersmeyer.

which he would be responsible) and the Center's staff, which he would manage.

His professional staff should include at least these categories of professional personnel: business manager, physician, behavioral scientist, public information specialist, health educator, senior computer specialist and statistician.


State and territorial Health Departments allocate less than ½ of one percent of their budget for health education.
SOURCE: October, 1971 Survey

Financing the Center

The Committee considered whether the Cen
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federally financed; or a mixture of the two. Det
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federal mandate, jointly financed by private and

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the appearance of excessive federal intervention)
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There are additional reasons for the choice:

1. An all-private entity could suffer from insuff

2. If the Center were all-governmental, the am
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3. An all-governmental organization could be
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4. Both governmental and private sectors a
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Both must work together in partnership—more
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as well as from government at all levels.

Projected Expenditures

The Committee projects that the operating
Center for its first five years would be $12-million

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State and territorial Health Departments allocate less than ½ of one percent of their budget for health education.
SOURCE: October, 1971 Survey

Financing the Center

The Committee considered whether the Center should be private and privately financed; totally within government and federally financed; or a mixture of the two. Deliberations led us to recommend the combination—a private organization with a federal mandate, jointly financed by private and public funds.

Excessive federal intervention in health education (or even the appearance of excessive federal intervention) could sap the vitality of professionals and institutions instead of energizing them. On the other hand, an organization made up only of private interests would lack the degree of influence and effectiveness that a combined private-governmental one would have.

There are additional reasons for the choice:

1. An all-private entity could suffer from insufficient funding.

2. If the Center were all-governmental, the amount of money available from year to year could be somewhat unpredictable because of other priorities that command government's attention.

3. An all-governmental organization could be vulnerable to political influence. In areas of health education which deal with highly personal and often sensitive issues, the Committee felt the government could less successfully promote positive, innovative programs.

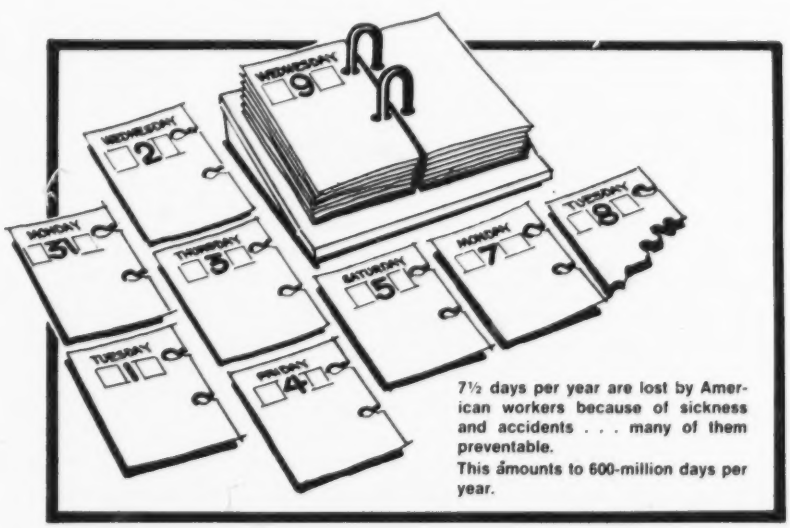
4. Both governmental and private sectors are already involved in health education programs to some degree. It seemed important to the Committee that both continue their significant work and that neither appear to usurp leadership from the other.

Both must work together in partnership—more closely than ever before if real results are to be seen. Through the Center, the private-governmental partnership could bring together the best of voluntary cooperation from all types of private interests as well as from government at all levels.

Projected Expenditures

The Committee projects that the operating budget of the Center for its first five years would be $12-million to $15-million.

The program budget would be substantially higher than that, its size depending upon the Center's ability to develop programs of high quality and to find both personnel and organizations competent to participate in their design and execution. All such programs would be capable of being measured and evaluated against stated goals and objectives.



7½ days per year are lost by American workers because of sickness and accidents . . . many of them preventable.
This amounts to 600-million days per year.

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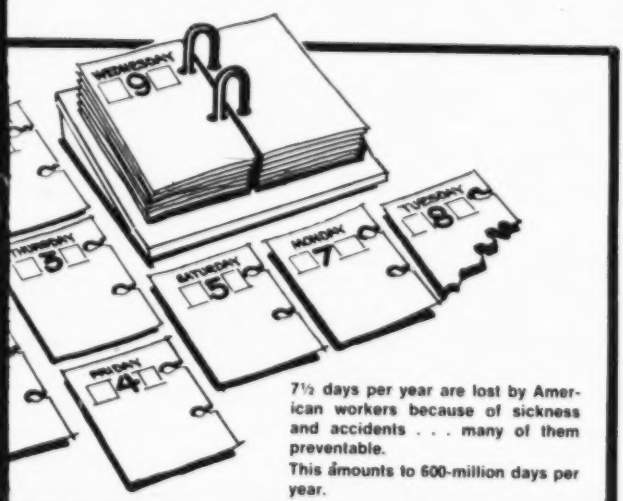


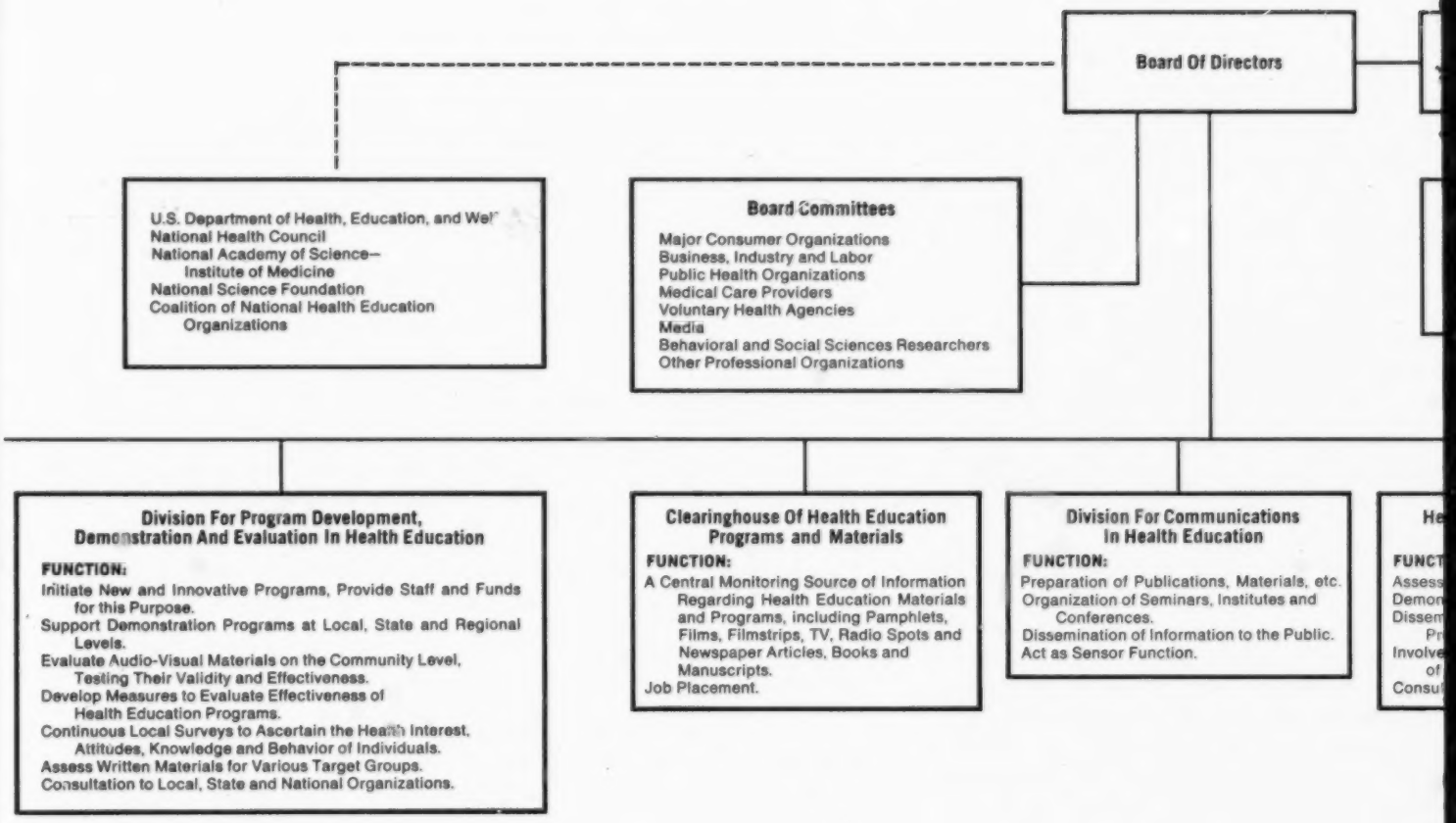
7½ days per year are lost by American workers because of sickness and accidents . . . many of them preventable.
This amounts to 600-million days per year.

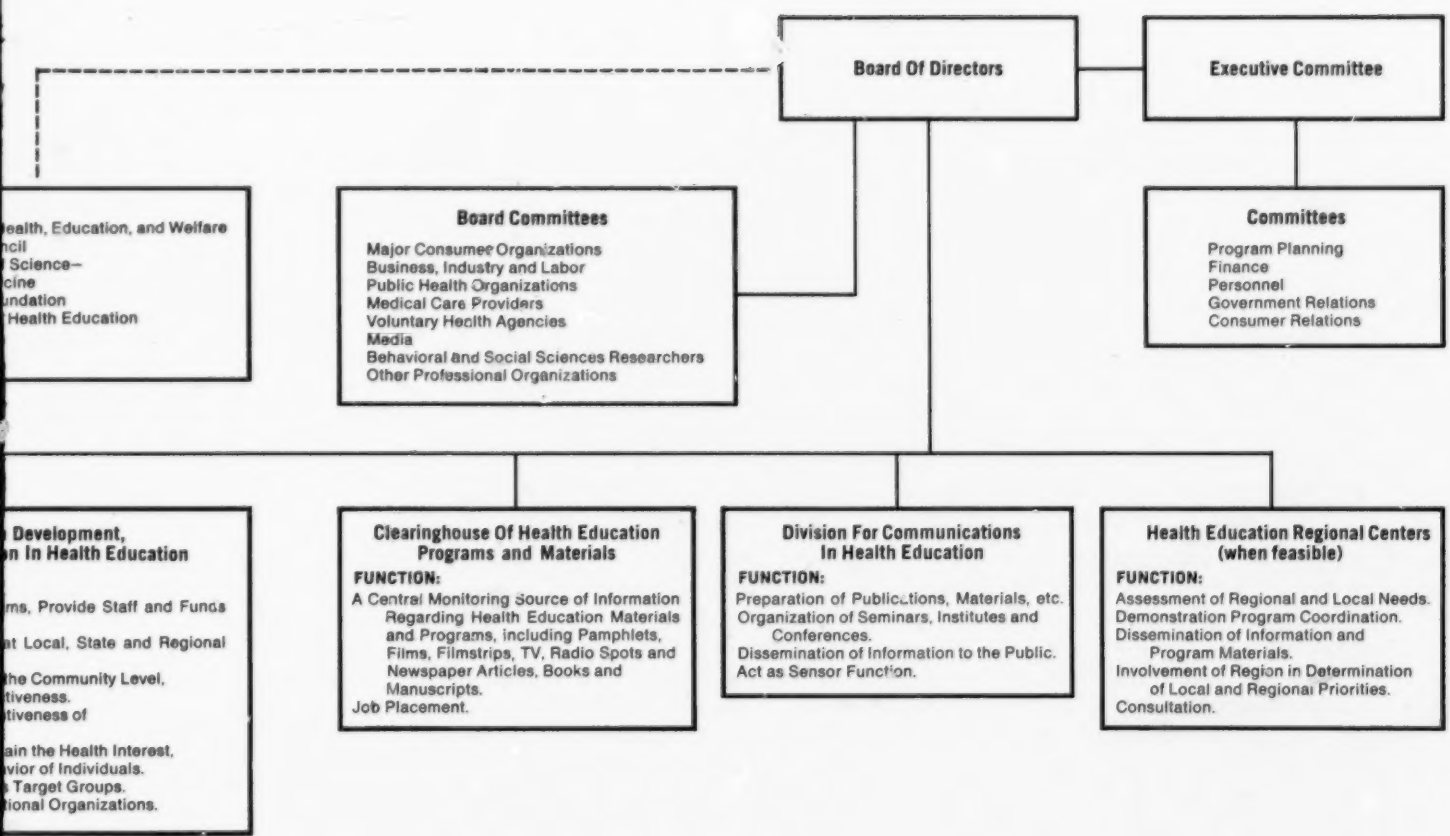
National Center For Health Education

Division For Research In Health Education

FUNCTION:

Initiate Research Into Methods o. Health Education.
Determine Most Effective Ways of Researching Various Target Groups and Determine Methods for Effective Health Education.
Basic Research in Communications, Attitudes and Behavior.
Motivation.


Board Of Directors
U.S. Department of Health, Education, and Wel
National Health Council
National Academy of Science–
Institute of Medicine
National Science Foundation
Coalition of National Health Education
Organizations
Board Committees
Major Consumer Organizations
Business, Industry and Labor
Public Health Organizations
Medical Care Providers
Voluntary Health Agencies
Media
Behavioral and Social Sciences Researchers
Other Professional Organizations
Division For Program Development,
Demonstration And Evaluation In Health Education
FUNCTION:
Initiate New and Innovative Programs, Provide Staff and Funds for this Purpose.
Support Demonstration Programs at Local, State and Regional Levels.
Evaluate Audio-Visual Materials on the Community Level, Testing Their Validity and Effectiveness.
Develop Measures to Evaluate Effectiveness of Health Education Programs.
Continuous Local Surveys to Ascertain the Health Interest, Attitudes, Knowledge and Behavior of Individuals.
Assess Written Materials for Various Target Groups.
Consultation to Local, State and National Organizations.
Clearinghouse Of Health Education
Programs and Materials
FUNCTION:
A Central Monitoring Source of Information Regarding Health Education Materials and Programs, including Pamphlets, Films, Filmstrips, TV, Radio Spots and Newspaper Articles, Books and Manuscripts.
Job Placement.
Division For Communications
In Health Education
FUNCTION:
Preparation of Publications, Materials, etc.
Organization of Seminars, Institutes and Conferences.
Dissemination of Information to the Public.
Act as Sensor Function.


Board Of Directors
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Major Consumer Organizations
Business, Industry and Labor
Public Health Organizations
Medical Care Providers
Voluntary Health Agencies
Media
Behavioral and Social Sciences Researchers
Other Professional Organizations
Committees
Program Planning
Finance
Personnel
Government Relations
Consumer Relations
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FUNCTION:
A Central Monitoring Source of Information Regarding Health Education Materials and Programs, including Pamphlets, Films, Filmstrips, TV, Radio Spots and Newspaper Articles, Books and Manuscripts.
Job Placement.
Division For Communications In Health Education
FUNCTION:
Preparation of Publications, Materials, etc.
Organization of Seminars, Institutes and Conferences.
Dissemination of Information to the Public.
Act as Sensor Function.
Health Education Regional Centers (when feasible)
FUNCTION:
Assessment of Regional and Local Needs.
Demonstration Program Coordination.
Dissemination of Information and Program Materials.
Involvement of Region in Determination of Local and Regional Priorities.
Consultation.

Supplementary Statements

M. ALFRED HAYNES, M.D.
Chairman
Department of Community Medicine
Charles R. Drew Post Graduate Medical School

I cannot endorse the recommendation of an operating budget of $12- to $15-million for the National Center even over a period of five years without at the same time insisting on accountability to the public. The expenditure of this amount may not be enough to do the job that has to be done, but it may be too much for what the Center may actually accomplish. One way of determining this is to hold the Center firmly responsible to the public. The Committee, as a whole, has been timid about making this recommendation because it does not know a perfect way to do so. Even an imperfect method of insuring accountability may be better than none at all if that method carries with it the flexibility to permit change. Furthermore, the element of public accountability could prove to be one of the most effective health education techniques that the Center could devise.

I propose that the Center be made accountable to a number of provider organizations such as the National Health Council and the Coalition of Health Educators and also a number of consumer organizations such as the National Consumer Health Organization and the National Chicano Health Organization. After a reasonable period of time, such as three years, and periodically thereafter, the Center would be under obligation to report to these organizations exactly what it has done and with what results. It is possible that the Center could generate so little interest that no organization could care whether it really existed. In that case, it should die a quiet and natural death or be painlessly defunded. If, on the other hand, its accomplishments were such as to justify additional expenditure of funds these organizations should not only endorse but contribute financially to its support.

Inherent in this approach is the risk that the Center may not survive but then no organization should survive if its performance does not merit survival.

RICHARD P. McGRAIL
Deputy Executive Vice Presi
American Cancer Society

1. I think the definition of health e
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have been listed as one of the major heal
report.

C. WREDE PETERSMEYE
Chairman and President
Corinthian Broadcasting Co

I believe that the Center should carry th
preparing creative, persuasive health infor
spots for television and radio; advertisemer
magazines, outdoor and transportation disp
for distribution through health agencies, com
mental offices. The Center should then be a
stations to carry such spots and with the prin
to carry such advertisements in the public i
charge. In order to carry out this responsi
staff should include as a key executive a p
ienced communicator. To assist him in hi
mobilize the services, on a volunteer basis,
the best creative talent in the private and pu

IRVING S. SHAPIRO, Ph.D
Director, Health Education Div
Health Insurance Plan of Greater N

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with the major recommendation that a Nation
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M. ALFRED HAYNES, M.D.
Chairman
Department of Community Medicine
Charles R. Drew Post Graduate Medical School

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RICHARD P. McGRAIL
Deputy Executive Vice President
American Cancer Society

1. I think the definition of health education could be strengthened. It might read somewhat as follows:

> Health Education is a planned process focusing on involvement of both health worker and consumer in its planning and implementation. Learning and behavior are facilitated through the two-way communication of information, knowledge, values and attitudes.

2. We may be somewhat prejudiced, but cigarette smoking is given very light treatment as a problem; we believe it should have been listed as one of the major health problems in the report.

C. WREDE PETERSMEYER
Chairman and President
Corinthian Broadcasting Corp.

I believe that the Center should carry the responsibility for preparing creative, persuasive health information promotional spots for television and radio; advertisements for newspapers, magazines, outdoor and transportation displays; and literature for distribution through health agencies, companies and governmental offices. The Center should then be able to arrange with stations to carry such spots and with the print and display media to carry such advertisements in the public interest and without charge. In order to carry out this responsibility, the Center's staff should include as a key executive a professional, experienced communicator. To assist him in his duties, he could mobilize the services, on a volunteer basis, of a task force of the best creative talent in the private and public sector.

IRVING S. SHAPIRO, Ph.D.
Director, Health Education Division
Health Insurance Plan of Greater New York

I am in full accord with the bulk of the report and particularly with the major recommendation that a National Center for Health Education of the Public be established. I do dissent from several

important statements and views in the report, as follows:

1. In Section II, "Purposes and Challenges of Health Education," the fact that health education has been fragmented and largely unevaluated is cited as resulting in a health care system overburdened with patients because of their lack of knowledge. If indeed our health care "system" is "overburdened," to blame it on patients who presumably would not be patients if only they had learned to behave more wisely is unacceptable and astonishing. It is far more likely that there is inefficiency because the system itself is fragmented and unevaluated.

The same unacceptable attitude is expressed in the statement shortly thereafter that people must meet the health care delivery system "at least half way." The presumption here is that they are equally, if not more, to blame for the failures in our "system."

The final expression of this unacceptable view is contained in the report statement that those served by the "providers of health care" share an obligation with them for "making a total health care system work." No reference is made to the role the consumer or citizen should play in determining the nature and shape of the "system" itself. Perhaps his responsibility is *not* to make the available "system" work, but to change it first!

2. In the section "Habit and Attitude Changes," it is stated that violations of common sense such as cigarette smoking, faulty diet, and drug abuse "represent a major weakness in the nation's past health education efforts." Since the burden of the report, correctly, is that health education in contradistinction to factual exhortations, appeals, and warnings, has not been adequately supported and tested, it may appear disingenuous to fault health education for the weakness inherent in the sole or major reliance on information packaging and delivery which characterizes the very situation we seek to change.

3. In the section "Environmental Protection," responsibility for pollution is assigned to "all of society." Yet only the public and industry are specified for the task of sharing in the costs and solution efforts. This, I feel, is a distortion of particular importance in view of the overwhelming threats to health that environmental pollution poses. The major force for achi
healthy environment in this country is goverr
national, state, and local levels, and in both the
executive branches.

This section as it stands, in a report on hea
clearly implies that if the public is educated to b
of the cost, industry will cut their pollution of the
undue noise, redesign goods and materials, and
abatement mechanisms. As experience demonstra
regional nature of the major pollution problems
governmental standards, controls, enforcement,
participation can truly begin to protect the pub
environmental hazards.

CHARLES A. SIEGFRIED
Vice Chairman of the Board
Metropolitan Life Insurance Compa

A number of aspects of the report cause
indicate certain of my concerns and reservatior
hand, the report appears to minimize both th
quality of what has been done and is being don
health education. On the other hand, it tends t
enormous complexities in the way of making signi
Numerous recommendations are made for extens
ties without any clear indication of just what they
plish, what they would likely cost, or whether
improvements would be commensurate with the

A major recommendation is that there be cre
Center for Health Education. Not only do I think
have more information than we currently have ava
sources of funds and the operational relationsh
posed organization, but I think more thought sho
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as an important function and which would be de
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Despite the great amount of commendable e

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atement that those served by the "providers of
are an obligation with them for "making a total
em work." No reference is made to the role the
izen should play in determining the nature and
system" itself. Perhaps his responsibility is *not*
ailable "system" work, but to change it first!

ection "Habit and Attitude Changes," it is stated
of common sense such as cigarette smoking,
drug abuse "represent a major weakness in the
alth education efforts." Since the burden of the
, is that health education in contradistinction to
ions, appeals, and warnings, has not been ade-
ed and tested, it may appear disingenuous to
ucation for the weakness inherent in the sole or
on information packaging and delivery which
e very situation we seek to change.

ection "Environmental Protection," responsibility
assigned to "all of society." Yet only the public
specified for the task of sharing in the costs and
This, I feel, is a distortion of particular impor-
the overwhelming threats to health that environ-
mental pollution poses. The major force for achieving a clean, healthy environment in this country is government, on the national, state, and local levels, and in both the legislative and executive branches.

This section as it stands, in a report on health education, clearly implies that if the public is educated to bear their share of the cost, industry will cut their pollution of the rivers, reduce undue noise, redesign goods and materials, and install smoke-abatement mechanisms. As experience demonstrates, and as the regional nature of the major pollution problems demands, only governmental standards, controls, enforcement, and financial participation can truly begin to protect the public health from environmental hazards.

CHARLES A. SIEGFRIED
Vice Chairman of the Board
Metropolitan Life Insurance Company

A number of aspects of the report cause me to wish to indicate certain of my concerns and reservations. On the one hand, the report appears to minimize both the volume and quality of what has been done and is being done in the way of health education. On the other hand, it tends to minimize the enormous complexities in the way of making significant changes. Numerous recommendations are made for extensive new activities without any clear indication of just what they might accomplish, what they would likely cost, or whether the hoped-for improvements would be commensurate with the costs.

A major recommendation is that there be created a National Center for Health Education. Not only do I think it desirable to have more information than we currently have available as to the sources of funds and the operational relationships of the proposed organization, but I think more thought should be given to the nature and significance of the research which is envisaged as an important function and which would be designed "to find ways to persuade people of different lifestyles to modify those styles in order to contribute to the quality of their lives."

Despite the great amount of commendable effort which has

gone into the Report, the vastness of the material and the importance of the subject strongly indicate the need for more deliberation before action programs can appropriately be recommended or new institutions be established.

SCOTT K. SIMONDS, DR. P.H.
Professor of Health Education
School of Public Health
University of Michigan

The opportunity to make a statement of dissent is appreciated, however, I prefer to write a "statement of conscience" rather than a statement of dissent to be included in the report. With the exception of the specific recommendation mentioned below, I can accept most of the report. I know that this tenth and final draft represents a synthesis of a great deal of information and a compromise of many opinions from members of the Committee and from the many people throughout the country who participated in our work. In consolidating information in the several drafts of the report, however, some of the most interesting and significant ideas have been lost that described ways in which health education could be advanced in this country. I think this is to be regretted.

As Chairman of the Committee on Education which focused its attention on health education of preschool and school age children, and college youths, I feel strongly that a wealth of testimony and expert opinion which we obtained in our Committee has surfaced only as the tip of an iceberg in the final report. Some of the substantive contributions have been lost entirely. Although much information must be condensed in a report of this kind, I do hope that the really important material brought together for the Committee can be utilized to support the work of the many community leaders and professionals in health education who have labored long and hard to achieve a higher quality of health education for the children and youth of this country, to whom we are ultimately accountable, and to set the stage for changes in social policy at the national level.

I am forced to dissent from the recommendation at the bottom of page 28 of the present copy prima
wording and hence its implications. It reads,
that schools of medicine, health science,
cooperate with schools of education to qua
and teachers to perform and administer hea
grams. Since every health education progra
by a professional health educator, serious co
be given to preparing selected persons as
effect, in the field of health education."

First of all, it is not at all clear who the
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In closing, I think it is regrettable that
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forced to dissent from the recommendation at the bottom of page 28 of the present copy primarily because of its wording and hence its implications. It reads, "Is recommended that schools of medicine, health science, and public health cooperate with schools of education to qualify administrators and teachers to perform and administer health education programs. Since every health education program cannot be run by a professional health educator, serious consideration should be given to preparing selected persons as 'paramedics,' in effect, in the field of health education."

First of all, it is not at all clear who the administrators are who are referred to in this statement. Administrators of community health education programs are already prepared in schools of public health and other programs accredited by the American Public Health Association. If school administrators are the focus, which I believe is the intent, then the sentence should so state. The phrase "to perform" implies "to perform health education programs," and the meaning is, therefore, not clear. I think the phrase "since every health education program cannot be run by a professional health educator" begs the question. There is a need for adequate training funds and funded positions to assure that as many programs in the community and in the schools as possible are indeed directed by professionally trained health educators. There is also a need, however, for health education aides, and much progress has already been made to define their roles and functions and to employ them in community health education programs. Their tasks are not administrative as implied in this recommendation, however, nor are they "paramedics" in any sense of the word. In my opinion they are "para-educs" if such a distinction is necessary.

In closing, I think it is regrettable that the name of the proposed national center has been shortened in this report from earlier versions to Center for Health Education without the designation that the public is to be the major focus of its attention. The problems that will arise through misinterpretation of the functions of the organization will be considerable. It will be assumed by many that the education of health manpower is the focus from the title alone when, indeed, it was our intent to direct attention to health education of the public.

J. HENRY SMITH
President
The Equitable Life Assurance Society

The basic theme of this Committee report is that health education of the public must be made more complete and effective if this nation is to achieve optimal improvement in its health status. That position seems unassailable. Furthermore, I agree that a broadly based "National Center," as a focal point of action and a catalyst, could effectively promote health education.

However, under the constraints of time and funding, the Committee was unable to deal in depth with the problems of health education and with the complexities and interrelationships involved in the concept of the "National Center." Consequently, I remain uneasy about this report in two respects.

First, there is a need for further clarification and development of the concept of the proposed Center. Certainly before it can be expressed in legislative form, there will have to be extensive development of such questions as to how the Center will relate to other agencies, institutions, and the government; how it will be financed in detail; and the process by which it will be held accountable to the American public.

Second, in an attempt to identify the realities of health education, this report makes a myriad of specific recommendations. While many of these are important and probably valid, again, within the constraints on the Committee, a number of the recommendations seem to me to be somewhat cursory. Some of them overlook the well documented warning of the report itself that the serious difficulties in health education include not only the dissemination of information but motivating people to use the information wisely. It would have been better, it seems to me, to have relegated the various problems to the proposed Center for attention. The Center, with careful study, experimentation and cooperative effort among the many groups concerned, should produce more valid and productive recommendations, and stimulate development of more effective programs, than our Committee was able to do in its life span.

ELLA L. STROTHER
Provident Comprehensive Neighborhood He
Baltimore, Maryland

Having examined and deliberated at great
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ELLA L. STROTHER
Provident Comprehensive Neighborhood Health Center
Baltimore, Maryland

Having examined and deliberated at great length over the final report of the President's Committee on Health Education, I find that I cannot support or approve the complete report. Therefore, I support the report only with reservations. While there is much in the report which I do support, my primary concern involves those parts which are inaccurate, or misleading. Among them are:

(1) The implication that the entire Committee rejected the idea that the Departments of HEW-OEO could not do the work as proposed for the new foundation. I do not and have not concurred in that decision.

(2) The report mentions meeting with the directors of neighborhood health centers, but it does not state that these directors made a special plea that the government extend the life of OEO and that the funds and purposes of HEW-OEO would not be eliminated nor diluted. This same appeal has been made by the poor and near poor people throughout the country. Yet the report has ignored this appeal and the harm, both mentally and physically, to the poor and near poor, which is already being done and which can be greatly increased by diverting both funds and functions of HEW-OEO.

While the report mentions manpower it lacks substantial substance and direction. There was insufficient information on the effect of low income and insufficient jobs for people who want to work. It is my position that the position of the lady who stated in effect, before the Committee "that she did not need anyone to tell her how to cook or what to cook, what she needed was a good job so she could buy what she knew she needed," reflects the opinion and plea of many. Third, the Committee's report does not do justice to the work and accomplishments of the Departments of HEW-OEO in elevating both the health and health education of the people in the community. The truth is

practically all of the recommendations made in the report are being executed in OEO and perhaps HEW funded health centers. The main weakness of HEW-OEO to date, is the lack of coordination. If any program is going to be accountable to the people rather than directed to the people, then the people, like institutions, must be given a reasonable time to organize.

The accountability of a national health center is lacking in the report. Many consumers have stated that federally funded health programs should be accountable to the people they propose to serve. I concur with that conclusion. If a national health center for health education is to serve the American public, it should be accountable to the American people and it should have more than token representation from the poor and near poor members of our society at every level of policy and decision making which affects them.

While some of the issues of "dissent" concerning the report of the President's Committee on Health Education as expressed by Dr. Joy G. Cauffman may not be completely obvious in the report, it is my opinion that the items of "dissent" have validity and it is unfortunate that greater attention was not paid to them.

Dissents

JOSEPH A. BEIRNE
President
Communications Workers of America, AFL-CIO

If the President's Committee on Health Education presents the proposed report to the President, I believe we will have missed, or at least delayed for a considerable time, an opportunity to change public attitudes toward health. It is with reluctance that I dissent from this report.

We already have lost five years. In late 1967, the National Advisory Commission on Health Manpower made recommendations on the kind of consumer-oriented health education envisioned by President Nixon when he formed the present Committee. I do not believe we will be doing the President a service by proffering this report, since Mr. Nixon showed so great an interest in health education in his Health Message to the Congress of February 15, 1971, and in his subsequent charge to the Committee.

The report, as presented for final ratification by members of the Committee, also does an injustice to the nearly 300 citizens and health professionals who testified at the eight public hearings, in my view.

I strongly believe that the National Center for Health Education, if formed within the framework of this report, will not be effective. And thus, in the future, it will be doubly difficult to do a proper job, because of a need to undo what has been improperly entered upon. I do not agree with the first sentence of the letter of transmittal that the Committee has completed its work, and I will explain briefly below.

In the letter of transmittal, the Committee would note that only $30-million is allocated in Fiscal 1973 for specific programs in health education, plus $14-million for general programs, both within the budget of the Department of Health, Education and Welfare. To that total of $44-million would be added up to $3-million a year, according to the final paragraph of Section IV, "Findings and Recommendations: National Center for Health Education." Thus, the letter of transmittal and Section IV tell the President that less than 25¢ per person per y for health education purposes. If we of the Co to tell the President that the proposed amou effect on health education, we will be doing a nation. Other portions of the proposed report, e II, describe a sizeable problem.

Section III proposes a private, nonprofit or Congressional mandate, financed jointly by Fe funds. The Corporation for Public Broadcastin those lines, for nearly five years has proven u because of the tangled relationship between sources of funds.

The central entity, which would serve as c fly," is the only logical means of achieving altogether too timidly in this report—seen is achieve only if the needed funds and personal a commitments are present.

In Section IV, I note that the Center woul information and expertise for lawmakers, but it on its own behalf for the necessary authorizatio tions. Since the proposed report does not stat advocate in the legislative process, there is the that there will be no advocate. Anyone who has tion with the legislative process in Washingto socially useful program must have strong adv yond the mere idea stage. The lack of definit for which I have asked since May 1972—as to th mitment from the professional health organizat the conclusion that that commitment is non-exi sible to find, anywhere in this draft report, the the chief professional health organizations; no find definitive information as to what the spec was able to achieve with the professional grou groups are key to success: American Medi American Hospital Association, American Publi tion, and American Dental Association. For ou meaning, I believe we should be able to tell t

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Section III proposes a private, nonprofit organization with a Congressional mandate, financed jointly by Federal and private funds. The Corporation for Public Broadcasting, established on those lines, for nearly five years has proven unable to function because of the tangled relationship between those two basic sources of funds.

The central entity, which would serve as catalyst and "gadfly," is the only logical means of achieving what we have—altogether too timidly in this report—seen is necessary. It will achieve only if the needed funds and personal and organizational commitments are present.

In Section IV, I note that the Center would be a source of information and expertise for lawmakers, but it would not lobby on its own behalf for the necessary authorization and appropriations. Since the proposed report does not state who will be the advocate in the legislative process, there is the strong possibility that there will be no advocate. Anyone who has had any connection with the legislative process in Washington is aware that a socially useful program must have strong advocates to go beyond the mere idea stage. The lack of definitive information—for which I have asked since May 1972—as to the degree of commitment from the professional health organizations leads me to the conclusion that that commitment is non-existent. It is impossible to find, anywhere in this draft report, the mere mention of the chief professional health organizations; nor is it possible to find definitive information as to what the special subcommittee was able to achieve with the professional groups. Four of these groups are key to success: American Medical Association, American Hospital Association, American Public Health Association, and American Dental Association. For our report to have meaning, I believe we should be able to tell the President that

these have joined in the efforts of the President's Committee on Health Education.

When in May 1972 I forwarded preliminary views on the Committee's work, I believed the Committee was not confronting the issues head-on. I do not see that situation changed in the final draft.

JOY G. CAUFFMAN, Ph.D.*
School of Medicine
University of Southern California

Having had such great faith and expectations in the work of the President's Committee on Health Education, it is with keen disappointment that I find it necessary to dissent from the Report to the President. My professional ethics and integrity, however, offer me no alternative. In preparing this dissent my goal has been to state the facts as I see them, and when possible, to offer constructive suggestions which will prove useful to individuals and groups who are interested in improving the quality of life and the health of the nation through health education.

Goals Left Unfulfilled

A careful analysis of the Report clearly demonstrates that the goals set forth in the President's Charg and held forth to the general public were new the Committee.

Committee Procedures Irregular

The Report represents the end product o by the Committee. Efforts leading to the Rep under conditions in which staff was permitte tee responsibility and in which Committee l fective in pursuing the President's assignm volved in producing the Report have not credibility. For example, information submitt either never reached or was censored befor Committee. Committee leadership involved its ingless exercises and failed to properly us resources.

The Nature and Meaning of Health Education D

The substance of the Report becomes d its failure to clearly focus on the subject o Obviously, health education should be the both the title of the Committee and the Charg explicitly state this responsibility. However, erly emphasizes ancillary issues such as the and public health, health problems, and h process of interweaving health education w issues, essential distinctions are not always and viable linkages are not always prov ancillary issues and health education. Thus tualization of the Report lacks rational thinki able perspective, and integration. Because deficiencies in the Report, the nature and education are heavily clouded and the Report professional in its misdirected effort to interpr to the public.

*On November 28, 1972, I prepared a first *Dissent*. It was based on the *Report of the President's Committee on Health Education* dated December 15, 1972 (ninth draft) which was distributed to the total Committee by the Chairman of the Editorial Subcommittee on November 22, 1972 for approval or dissent within ten days. Subsequently, the December 15, 1972 Report was altered but without repolling of the total Committee. (This altered draft was dated December 11, 1972.)

On December 29, 1972, I prepared a second *Dissent* which is basically the same as my first *Dissent* but which takes into account alterations appearing in the tenth draft. This second *Dissent* is based on the *Report of the President's Committee on Health Education* dated December 11, 1972 (tenth draft) which was distributed at some later date to some members of the Committee before it was submitted to the Secretary of Health, Education and Welfare on December 14, 1972. (If the reader is confused by the dates given, please note that the Report dated December 15, 1972 preceded the Report dated December 11, 1972.)

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Unfulfilled

reful analysis of the Report clearly demonstrates that the goals set forth in the President's Charge to the Committee and held forth to the general public were never fully achieved by the Committee.

Committee Procedures Irregular

The Report represents the end product of over a year's work by the Committee. Efforts leading to the Report were conducted under conditions in which staff was permitted to usurp Committee responsibility and in which Committee leadership was ineffective in pursuing the President's assignment. Processes involved in producing the Report have not contributed to its credibility. For example, information submitted to the staff often either never reached or was censored before reaching the Full Committee. Committee leadership involved its members in meaningless exercises and failed to properly use their talents and resources.

The Nature and Meaning of Health Education Distorted

The substance of the Report becomes distorted because of its failure to clearly focus on the subject of health education. Obviously, health education should be the central issue since both the title of the Committee and the Charge to the Committee explicitly state this responsibility. However, the Report improperly emphasizes ancillary issues such as the history of medicine and public health, health problems, and health care. In the process of interweaving health education with other ancillary issues, essential distinctions are not always clearly delineated and viable linkages are not always provided between the ancillary issues and health education. Thus, the total conceptualization of the Report lacks rational thinking, continuity, suitable perspective, and integration. Because of these significant deficiencies in the Report, the nature and meaning of health education are heavily clouded and the Report becomes less than professional in its misdirected effort to interpret health education to the public.

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Leadership Opportunities for Professional Health Educators Denied

The Report does not provide the leadership opportunities which professional health educators rightfully deserve and are capable of assuming. The chance to remove any prejudicial barrier which may stand between their professional capability and achievement is lost. For example, the Report should, but does not, specify that the National Center for Health Education will have both an administrator and a Health Education Director. The Director should be a professional health educator with background and experience in community and school health education and should hold a position in the Center which is analogous to a position held by a physician who is a Medical Director in a hospital. Further, the Report should, but does not, specify that professional community and school health educators should share leadership roles for health education at high policy making and administrative levels within Federal, State, and Local Government.

Support for Critical Health Educator Manpower Shortages Omitted

The Report reflects the need for increased health educator manpower in the United States, particularly in early childhood, school, and hospital settings. At the same time, the Report fails to recommend support of training programs for professional health educators, but conversely recommends support of training programs for non-professionals such as "paramedics" and volunteers who are to perform health education functions. Extending non-professional manpower in health education without proportionate expansions in already depleted professional health educator ranks places an unrealistic burden on existing manpower. Therefore, the Federal Government should, as a manpower priority, extend its present training programs for community health educators to include school health educators. The over 100 institutions of higher education in the United States that prepare professional health educators and that are capable of contributing a strong basic health science input should conduct these training programs.

The Unified Voice for the Health Education Profession Ignored

The Report discriminates against the Coa Health Education Organizations* representing of the health education profession and consist health education organizations in the United S fiable health educator memberships and on-go tion programs. This is apparent since only a is made to the Coalition in the Table of Org National Center for Health Education. This clearly shows that the Coalition would have establishing Center policy. In an effort which a ing a comprehensive nationwide health educati inconceivable that the primary full time pro education services in this country are virtually ing the profession dissipates valuable trained tributing to the nation's health. As a result, the stand to lose.

Value of Mass Media Not Fully Recognized

While no health education program can be ful implemented through only mass media, it w important for the Report to clearly specify th mass media's involvement since media have p favorably and unfavorably influencing the qu millions of Americans. The Report does pay pa the subject of mass media in relation to the Na Health Education, but otherwise neglects to e linkages between health education practitioners specialists within both large networks and loca

*Member organizations of the Coalition include the A for Health, Physical Education, and Recreation, School American College Health Association, Health Education S Public Health Association, Public Health Education Sectio Section; the American School Health Association, the Co Territorial Directors of Public Health Education; the Socie of Health, Physical Education, and Recreation; and the Soc Education, Inc.

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The Unified Voice for the Health Education Profession Ignored

The Report discriminates against the Coalition of National Health Education Organizations* representing the unified voice of the health education profession and consisting of all national health education organizations in the United States with identifiable health educator memberships and on-going health education programs. This is apparent since only a single reference is made to the Coalition in the Table of Organization for the National Center for Health Education. This single reference clearly shows that the Coalition would have no direct role in establishing Center policy. In an effort which anticipates mounting a comprehensive nationwide health education program, it is inconceivable that the primary full time providers of health education services in this country are virtually ignored. Thwarting the profession dissipates valuable trained resources contributing to the nation's health. As a result, the American people stand to lose.

Value of Mass Media Not Fully Recognized

While no health education program can be fully and effectively implemented through only mass media it would have been important for the Report to clearly specify the dimensions of mass media's involvement since media have potential for both favorably and unfavorably influencing the quality of life for millions of Americans. The Report does pay passing attention to the subject of mass media in relation to the National Center for Health Education, but otherwise neglects to encourage sound linkages between health education practitioners and mass media specialists within both large networks and local outlets.

*Member organizations of the Coalition include the American Association for Health, Physical Education, and Recreation, School Health Division; the American College Health Association, Health Education Section; the American Public Health Association, Public Health Education Section and School Health Section; the American School Health Association, the Conference of State and Territorial Directors of Public Health Education; the Society of State Directors of Health, Physical Education, and Recreation; and the Society for Public Health Education, Inc.

National Center for Health Education Unaccountable to the Nation

The Report projects, "the operating budget of the Center for the first five years would be $12 million to $15 million" and "The program budget would be somewhat higher. . . ." The budget projections however do not specify major categories of anticipated expenditures and do not relate expenditures to functions of the Center. Therefore, specification of functional priorities within the Center have not been delineated within the Report. In addition, the Report also fails to develop a plan of evaluation, including accountability for Center functions. Such an omission is particularly difficult to understand in light of the numerous findings and recommendations on the subject of evaluation within the Report, and in view of the role the Center will play in evaluating the health education efforts of others. If clearly described evaluation programs apply to all other health education programs, the Center should not be immune; to the contrary, the Center must play an exemplar role. Furthermore, since the Center is to serve the American public, it must be accountable to the people. To do otherwise is hypocrisy.

American People Victims of False Promises

All who wished to testify at the Regional Hearings held in major cities across the nation during January, 1972 were given an opportunity to be heard. Many speakers waited endless hours to testify and were promised that their presentations would be given careful attention. It is a grievous fault that the Full Committee never reviewed the total input in recorded form or through a carefully prepared summary. This casual treatment of information by the Committee demonstrates its failure to utilize the full range of information received in selecting major ideas for the Report.

Following the *National Health Forum* which was held in New Orleans in March, 1972, *Medical World News* reported that the Committee did not keep its promise to participants by providing preliminary findings at the Forum. This was true. Participants at the Forum, however, were assured by Committee leadership that their input would be careful
Full Committee. This was not done. Even m
fact that the body of the Report does n
National Health Forum.

Implementation and Follow-up Disregarded

The Report includes over 30 recomm
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The fact is that many of the recommenda
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COMMENTS BY VICTOR WEINGARTE

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Implementation and Follow-up Disregarded

The Report includes over 30 recommendations under the label of "National Activities in Support of Health Education." The fact is that many of the recommendations address themselves to responsibilities which should be carried out by or in cooperation with state and local leadership. In addition, supportive evidence to clarify the recommendations and to make implementation readily feasible is missing from the Report. As examples, the Report recommends that model laws for school health education programs be encouraged, but fails to suggest content to be included in such laws and the Report further recommends that the Nation's hospitals provide health education programs, but fails to suggest the nature and scope of such programs. The Report should contain guidelines for immediate action and follow-up of the Report at community, state and national levels and should provide a blueprint for future planning and action associated with a comprehensive nation-wide health education effort.

COMMENTS BY VICTOR WEINGARTEN, DIRECTOR

Dr. Cauffman's prime concern seems to be that she would like to have a larger role assigned to the "Coalition of National Health Organizations" which she currently heads. Contrary to her complaints, the Coalition is recognized as one of the major —but not the sole—professional organization which can play a role in implementing the Committee's primary recommendation. Another prime concern of Dr. Cauffman relates to her apparent belief that the report ought to be more forceful in attempting to support the injection of professional health educators into virtually every walk of life wherein health education is important. Most of the Committee were unable to support the extent and scope of these recommendations, albeit recognizing the impor-

tance of professional health educators as the report does. It seems apparent that professional health educators have important work to do in inducing enlarged public support for their activities.

We regret the misunderstanding which has led to Dr. Cauffman's complaint about the sharing of data. Data collected from all sources were made available, not to all members of all subcommittees, but to the appropriate subcommittees on which members served. Dr. Cauffman, for example, received all papers and testimony relating to school health education, her primary study area. No member received copies of all 2,000 papers, 71 hours of testimony, reports, etc., although all Committee members received a summary of analysis of all testimony at all regional hearings, especially prepared for the Committee by the American Institutes for Research.

In addition, a major portion of one Committee meeting was devoted to an exchange of experiences and information about members' participation in the eight regional hearings.

And finally, Dr. Cauffman would prefer that there be included more details with respect to a number of the recommendations of the report. Most of the Committee believed that such details should be left to the implementing responsibility of the proposed Center and of the myriad of public and private organizations whose work impacts upon effective health education.

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